

# Whole Health System Implementation Guide

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**VA**



**U.S. Department of Veterans Affairs**

Veterans Health Administration  
Office of Patient Centered Care and  
Cultural Transformation



*Office of Patient Centered Care & Cultural Transformation*

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## 1. About this Guide

### Welcome to the *Whole Health System (WHS) Implementation Guide!*

The VA is committed to large-scale implementation of the Whole Health System. Delivering Whole Health is a key component of VHA Modernization efforts and is embedded within the Department of Veterans Affairs 2018-2024 Strategic Plan. By referencing this guide, you are demonstrating your own personal and professional commitment to achieving Whole Health transformation across the enterprise. Thank you for this commitment! We are delighted to have you along with us on this journey.

**Version 4.0 of the *Whole Health System Implementation Guide (WHIG)* has been revised to be fully aligned with the [Designation Framework for Whole Health Implementation](#)**

([https://dvagov.sharepoint.com/:w:/s/VHAOPCC/EUdWEp9OfqtGt3wL4-](https://dvagov.sharepoint.com/:w:/s/VHAOPCC/EUdWEp9OfqtGt3wL4-VZ3mIBIRzn6chrEYAyqfc7ffTdyw?e=flmsq5)

[VZ3mIBIRzn6chrEYAyqfc7ffTdyw?e=flmsq5](https://dvagov.sharepoint.com/:w:/s/VHAOPCC/EUdWEp9OfqtGt3wL4-VZ3mIBIRzn6chrEYAyqfc7ffTdyw?e=flmsq5)), a visionary document released by the Office of Patient Centered Care & Cultural Transformation (OPCC&CT) in March 2019.

**The *WHIG* also aligns with and supports the [Whole Health System Self-Assessment Tool](#)**

(<https://vaww.whsassessmenttool.va.gov/login/>) that was released as a companion to the *Designation Framework* document. Together, these three resources work to support the implementation of Whole Health across the system as described below:

- The *Designation Framework for Whole Health Implementation* addresses the question, “**Where are we going?**” by describing the future state when the Whole Health System is implemented. It describes desired outcomes along the four phases of the Whole Health implementation journey. To achieve these outcomes, key milestone accomplishments have been identified and organized around seven domains: Governance, Operations, Pathway, Well-being, Whole Health Clinical Care, Employee Whole Health, and Community Partnerships. It is important to note that the *Designation Framework* is **not intended** to prescribe exactly *how* a site achieves each accomplishment. Instead, the goal is to provide sites with latitude and flexibility in how they choose to operationalize Whole Health processes and practices.
- The *Whole Health System Self-Assessment Tool (WHSSAT)* addresses the question, “**Are we there yet?**” Accomplishments from each phase of the *Designation Framework* have been transferred into this tool as discrete elements that can be scored individually. Intended for individual site use, the *WHS Self-Assessment Tool* can aid a site in identifying and organizing Whole Health initiatives and priorities.
- This publication, the *Whole Health System Implementation Guide (the “Guide”)*, addresses the question, “**How can we implement Whole Health?**” It provides sites with information, context, and guidance surrounding Whole Health implementation activities, as well as offers examples of how the various accomplishments could be met.

All of these tools are recommended to be used in conjunction with other OPCC&CT resources and with OPCC&CT Field Implementation Team (FIT) consultation.

**This *Guide*, and its supporting SharePoint document libraries, includes both facility and VISN-level examples of Whole Health implementation (e.g., templates, scripts, organizational charts, policies, resources, etc.) to supplement national guidance. These examples have been generously shared by your fellow VA Whole Health colleagues. Please note that they are *not***

intended to be prescriptive. In other words, these examples illustrate *one way* to implement Whole Health, not necessarily the *only way*. As such, sites are encouraged to use these examples as inspiration for creating their own unique approaches to implementing Whole Health that address the needs of their local facilities and Veteran populations.

Within this *Whole Health System Implementation Guide* you will find:

- An **overview of the Whole Health System model of care** for any site or staff member unfamiliar with the underlying concepts of Whole Health and/or the need for transformation.
- A **Quick-Start guide to Whole Health implementation**. This chapter will be particularly helpful to those sites just starting their Whole Health journey and who are wondering where to begin.
- A **separate chapter devoted to each of the seven domains of the *Designation Framework for Whole Health Implementation***: Governance, Operations, Pathway, Well-being, Whole Health Clinical Care, Employee Whole Health, and Community Partnerships. Sites can use the in-depth guidance found within these sections to address any identified implementation gaps to enhance efforts in one or more areas of focus. Each chapter also includes links to targeted resources.
- A **chapter devoted to the process of evaluating Whole Health implementation efforts**, particularly the use of the online WHS Self-Assessment Tool.

#### **Additional Resources:**

In addition to the substantial guidance and information contained within this *Guide*, for ongoing support **the reader is invited to explore—and bookmark—OPCC&CT's [Whole Health Hub SharePoint page](https://dvagov.sharepoint.com/sites/VHAOPCC/sitepages/index.aspx)** (<https://dvagov.sharepoint.com/sites/VHAOPCC/sitepages/index.aspx>).

This site is a one-stop-shop on all things Whole Health. New/revised Whole Health resources, announcements and updates, implementation examples from the field, information about OPCC&CT's numerous Whole Health-related Community of Practice (CoP) calls, and many other tools and reference materials can all be found on this SharePoint.

Finally, in support of this guide, **a separate SharePoint document library has been set up for each of the seven domains of the *Designation Framework***, as well as for Whole Health-related Human Resource documents. These libraries will be continually updated as new resources are identified. **The libraries can always be accessed independently of this *Guide* by visiting the [Whole Health Hub SharePoint site](https://dvagov.sharepoint.com/sites/VHAOPCC/sitepages/index.aspx)** (<https://dvagov.sharepoint.com/sites/VHAOPCC/sitepages/index.aspx>) and navigating to the Implementation Resources section.

#### **Domain-Specific Document Libraries:**

[Governance Domain SharePoint Document Library](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Governance_Domain/Forms/AllItems.aspx) ([https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Governance\\_Domain/Forms/AllItems.aspx](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Governance_Domain/Forms/AllItems.aspx))

[Operations Domain SharePoint Document Library](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Operations_Domain/Forms/AllItems.aspx) ([https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Operations\\_Domain/Forms/AllItems.aspx](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Operations_Domain/Forms/AllItems.aspx))

[Pathway Domain SharePoint Document Library](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Pathway_Domain/Forms/AllItems.aspx) ([https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Pathway\\_Domain/Forms/AllItems.aspx](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Pathway_Domain/Forms/AllItems.aspx))

[Well-being Domain SharePoint Document Library](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WellBeing_Domain/Forms/AllItems.aspx) (https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WellBeing\_Domain/Forms/AllItems.aspx). *Be sure to check out the Integrative Health Coordinating Center (IHCC) section of the Whole Health Hub at the link above for more information about the complementary and integrative health approaches that are a part of this domain.*

[Whole Health Clinical Care Domain SharePoint Document Library](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WH_Clinical_Care_Domain/Forms/AllItems.aspx)  
(https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WH\_Clinical\_Care\_Domain/Forms/AllItems.aspx)

[Employee Whole Health Domain SharePoint Document Library](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Employee_WH_Domain/Forms/AllItems.aspx)  
(https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Employee\_WH\_Domain/Forms/AllItems.aspx). *Be sure to check out the Employee Whole Health section of the Whole Health Hub at the link above for more information about this domain.*

[Community Partnerships Domain SharePoint Document Library](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Community_Domain/Forms/AllItems.aspx)  
(https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Community\_Domain/Forms/AllItems.aspx)

[Whole Health Human Resources SharePoint Document Library](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WHHumanResources/Forms/AllItems.aspx)  
(https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WHHumanResources/Forms/AllItems.aspx)

## 2. Whole Health System: Overview

**Whole Health (WH)**, also known as “Personalized, Proactive, Patient-driven Care,” is an approach to healthcare that empowers and equips people to take charge of their health and well-being and to live their life to the fullest. This aligns with the Veterans Health Administration (VHA) Mission Statement to Honor America’s Veterans by providing exceptional health care that improves their health and well-being.

### 2.1 Why

Our country has built a healthcare system which does very well at treating many diseases —but which does not focus enough on creating and supporting health and well-being. Because of this focus on high-tech disease treatment, the U.S. spends far more than any other country on health care but ranks only 32nd in life expectancy.<sup>1</sup> We must create a health system, rather than a disease care system. We must expand our understanding of what defines healthcare, developing a Whole Health System that empowers and equips people to take charge of their health and well-being. The VHA is uniquely positioned to make this a reality - for our Veterans, and for our Nation.

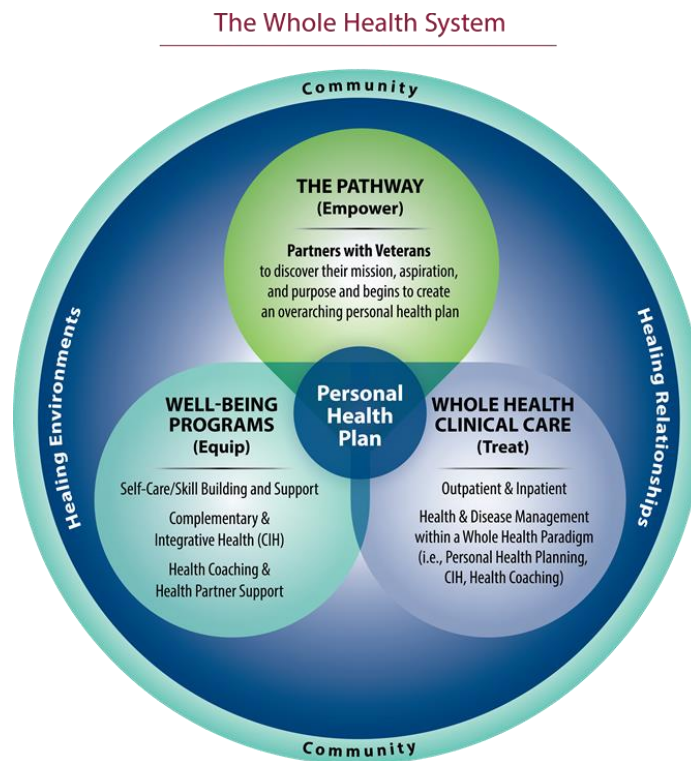


Figure 1: Components of the Whole Health System model of care

### 2.2 What

Whole Health is an approach to healthcare that empowers and equips people to take charge of their health and well-being and to live their life to the fullest. VHA facilities have been exploring what it takes to shift from a system designed around episodic points of clinical care primarily focused on disease management, to one that is based in a partnership across time focused on Whole Health. We have

learned that clinical encounters are essential but not sufficient. We need a health system focused not only on treatment but also on self-empowerment, self-healing, and self-care.

Veterans are encouraged to consider these important questions:

1. “What REALLY matters to you in your life?”
2. “What brings you a sense of joy and happiness?”
3. “What do you want your health for?”

**The Whole Health System includes three main components:**

**1. Pathway: Peers EMPOWER Veterans through the Pathway**

In a partnership with Veteran peers, Veterans and their family are supported in exploring their Mission, Aspiration, and Purpose (MAP), and in developing their Personal Health Plan (PHP). VHA partners with Veterans from the point of enrollment and throughout their relationship to explore their MAP and to develop their PHP, as well as integrating care in the VHA and the community. The Pathway programming can be offered in the VHA facility or the community, and can include family and caregivers. To facilitate the Pathway, VHA has created a formal role for peers who partner with Veterans across time. The Pathway programming may include:

- Whole Health Orientation provides a connection to Pathway options, via the *Introduction to Whole Health* course
- Ongoing support may include:
  - Peer support & Whole Health partners (individual or group), and/or
  - Health and wellness coaches (individual or group)
- Core Program emphasizes exploring what matters most to the Veteran, identifying ways to enhance self-care, and creating a PHP. This may include:
  - Whole Health peer-led group programs – *Taking Charge of My Life & Health* (virtual or in person; in VHA or community settings), and/or
  - Online Pathway options

**2. Well-being Programs: EQUIP Veterans with Well-being**

The core offerings of Well-being Programs teach new skills that support self-care, including complementary and integrative health (CIH) approaches, self-care practices, and Whole Health coaching. Well-being offerings may be accessible within the VHA setting or in the community.

- Well-being Programs are not disease focused. Instead, they focus on improving health through self-care and CIH approaches that optimize health and well-being, including partnering with a health and wellness coach
- Teams may include an integrative nutritionist, movement therapists and teachers (e.g., yoga, Tai Chi, Qigong), licensed acupuncturists, mind-body therapists (e.g., stress reduction, guided imagery, clinical hypnosis), health coaches, and others
- Veterans may be seen individually with a health and wellness coach in support of their PHP; however, the primary services are focused on self-care skill building and ongoing classes for support
- These programs have strong relationships with Whole Health Clinical Care and Pathway programming, including referrals to and from primary care, other service lines, and Whole Health partners

### 3. Whole Health Clinical Care: TREAT Veterans with Whole Health Clinical Care

In VHA facilities, the community, or both, clinicians trained in Whole Health deliver excellent clinical care that empowers and equips Veterans to live their lives fully in support of their MAP. This includes a shared partnership between the care provider and Veteran to develop shared goals connecting to their MAP. Whole Health Clinical Care may be provided in multiple settings. Treatment plans may integrate CIH approaches and provide care in healing environments, fostering healing relationships. In order to truly practice in a Whole Health model, clinicians connect back to the Pathway and Well-being elements throughout the Veteran's healthcare journey. Whole Health Clinical Care is a team effort that occurs over the course of time.

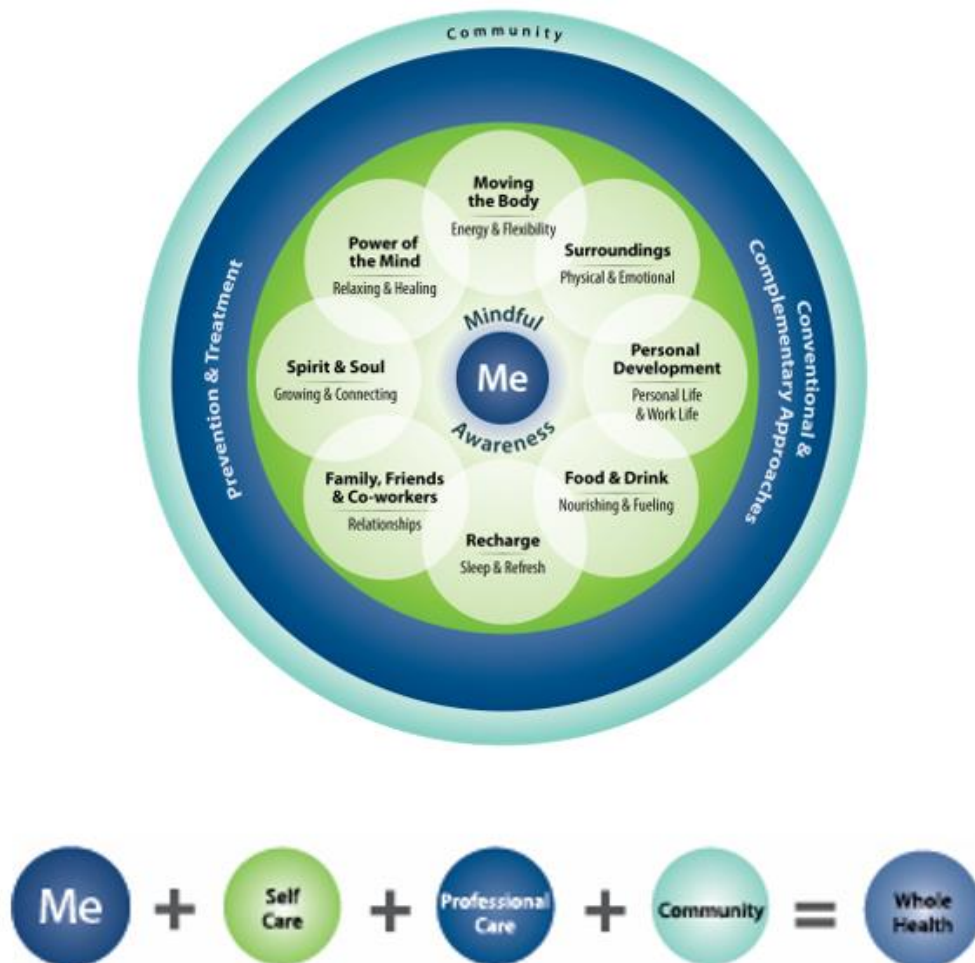


Figure 2: The Whole Health Approach

## 2.3 Preliminary Findings: Veteran Impact

The Whole Health approach not only partners with Veterans to improve their whole health but is also critically important for Veterans with complex conditions, such as chronic pain and the invisible wounds of war. Additionally, the Whole Health approach can improve patient reported outcomes. **Preliminary research from Whole Health Flagship Sites shows:**<sup>2</sup>

- 31% of Veterans with chronic pain engaged in some Whole Health services
- There was a threefold reduction in opioid use among Veterans with chronic pain who used Whole Health services compared to those who did not. Opioid use among comprehensive Whole Health users decreased 38% compared with only an 11% decrease among those with no Whole Health use
- Compared to Veterans who did not use Whole Health services, Veterans who used Whole Health services reported:
  - Greater improvements in perceptions of the care received as being more patient-centered
  - Greater improvements in engagement in healthcare and self-care
  - Greater improvements in engagement in life indicating improvements in mission, aspiration and purpose
  - Greater improvements in perceived stress indicating improvements in overall well-being

*Preliminary data reflects impressive results in employee engagement, as well as early signs of potential cost avoidance in the areas of pharmacy and outpatient care.*

## 2.4 Whole Health Cultural Transformation: Employee Whole Health

Employees operating in a Whole Health System of care are encouraged to be active participants in their own health and well-being! The mission of Employee Whole Health (EWH) is to create an environment that encourages VHA staff to adopt healthy behaviors and approaches that promote self-care and well-being, reduce the incidence of preventable illness and injury, and foster a culture of employee engagement that results in the best care and improved access for Veterans.

Employee Whole Health supports employee health initiatives that help employees live their best lives in alignment with what matters most to the individual. Many programs aligned with the Circle of Health can help employees reduce their risk of chronic illness and optimize their health and well-being. Participation in activities such as yoga and Tai Chi, developing a meditation practice, or using guided imagery can benefit employees. Finally, employees who have experienced Whole Health options are better able to have an informed discussion with their patients about options.

**Preliminary research from the Whole Health Flagship Sites shows:**

- Employee involvement in provision of Whole Health expanded from 2018-2019 in all sites
- Variation exists in different clinical areas, with the greatest integration in primary care, mental health, rehabilitation, and home/community care
- Employees who reported involvement with Whole Health also reported their facility as a ‘best place to work’; lower voluntary turnover; lower burnout; and greater motivation



- Facilities with higher employee involvement in Whole Health had higher ratings on hospital performance, as measured by Strategic Analytics for Improvement and Learning (SAIL)
- Facilities with higher employee involvement in Whole Health had higher ratings from Veterans on receiving patient-centered care as measured in the Survey of Healthcare Experiences of Patients (SHEP)

## References

<sup>1</sup>World Health Organization. (2018 April 6). Life Expectancy at Birth (years).

[https://www.who.int/data/gho/data/indicators/indicator-details/GHO/life-expectancy-at-birth-\(years\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/life-expectancy-at-birth-(years))

<sup>2</sup>Bokhour BG, Hyde JK, Zeliadt S, Mohr DC. Whole Health System of Care Evaluation- A Progress Report on Outcomes of the WHS Pilot at 18 Flagship Sites. 2020. VHA Center for Evaluating Patient-Centered Care in VA (EPCC-VA). <https://www.va.gov/WHOLEHEALTH/professional-resources/clinician-tools/Evidence-Based-Research.asp>



### 3. A Quick Start Guide to Whole Health Implementation

For those sites just beginning their Whole Health (WH) journey, or those early in the process, **this chapter is intended to provide a high-level look at the core elements of the Whole Health System (WHS) that will need to be established.** It also suggests some possible initial implementation steps that could be taken to get started. Before proceeding further, it is strongly recommended that the reader refer to section 2. [Whole Health System: Overview](#) for important background and contextual information about the Whole Health approach.

#### 3.1 Overview

**The WHS includes three major components** that align to support the creation of a Personal Health Plan (PHP) based on each patient's values, conditions, needs and circumstances: The Pathway (Empower), Well-being Programs (Equip), and Whole Health Clinical Care (Treat).

The Pathway
Veterans partner with their families and peers to explore their mission, aspiration, and purpose (MAP) and begin their Personal Health Plan.
<b>The Pathway includes:</b>
<ul style="list-style-type: none"><li>• <b>Introduction to Whole Health:</b> Important information about the Whole Health approach and available offerings.</li><li>• <b>Taking Charge of My Life and Health (TCMLH):</b> Allows Veterans to explore what matters most in their lives.</li><li>• <b>On-going Support:</b> Peer support, and/or Whole Health partners (including volunteers), and/or health coaches as facilitators can be leveraged individually or in group settings.</li></ul>

Well-being Programs
Sites have the ability to start or strengthen programs to support Veteran well-being. Programs may connect to existing services or provide new offerings, including complementary and integrative health (CIH) approaches.
<b>Prioritized core offerings:</b>
<ul style="list-style-type: none"><li>• <b>List 1 CIH Services:</b> acupuncture, biofeedback, clinical hypnosis, guided imagery, massage therapy, meditation, Tai Chi/Qigong, yoga, and chiropractic care. (Note: VHA chiropractic care is administered by the <a href="http://vawww.rehab.va.gov/CS/index.asp">Chiropractic Program Office</a> (<a href="http://vawww.rehab.va.gov/CS/index.asp">http://vawww.rehab.va.gov/CS/index.asp</a>).</li><li>• <b>9 Class Tracks:</b> Introduction/Orientation; Surroundings; Personal Development; Food &amp; Drink; Recharge; Family, Friends, Co-Workers; Spirit &amp; Soul; Power of the Mind, Moving the Body.</li><li>• <b>Health Coaching:</b> Individual and group coaching services.</li></ul>
<i>Enrollment should not be based on a specific disease or diagnosis.</i>

Whole Health Clinical Care
<p>With Whole Health, conventional medicine can be used alongside CIH offerings and personalized health planning to provide a Veteran-centered, innovative approach to self and overall care.</p> <p><b>A Clinician will:</b></p> <ul style="list-style-type: none"> <li>• Work with the patient to understand his or her current health and well-being.</li> <li>• Support the patient in setting and achieving realistic goals.</li> <li>• Discuss a range of available resources, including CIH and overall WHS resources.</li> </ul> <p><i>This is an on-going paradigm shift that will occur over time with active communication.</i></p>

Personal Health Plan
<p><b>A Personal Health Plan:</b></p> <ul style="list-style-type: none"> <li>• Serves as a living document that grounds the approach to care in what matters most to the Veteran.</li> <li>• Forms the basis of decision-making and treatment planning as the Veteran engages in their care plan with the support of their care team.</li> </ul> <p><b>During personal health planning, a Veteran:</b></p> <ul style="list-style-type: none"> <li>• Identifies their mission/aspiration/purpose (MAP).</li> <li>• Completes a Whole Health Assessment with a Personal Health Inventory (PHI).</li> <li>• Sets shared and detailed goals.</li> <li>• Develops an action plan with skill building resources.</li> </ul> <p><b>Available Tools:</b></p> <ul style="list-style-type: none"> <li>• MAP Resource</li> <li>• Personal Health Inventory</li> <li>• Brief Personal Health Inventory</li> <li>• <a href="https://www.myhealth.va.gov/mhv-portal-web/web/myhealthvet/healtheliving-assessment">Health living assessment (HLA) through MyHealthVet</a> (https://www.myhealth.va.gov/mhv-portal-web/web/myhealthvet/healtheliving-assessment)</li> <li>• SMART Goal Form</li> </ul>

### 3.2 Initial Offerings

Veterans benefit from starting their Whole Health journey by attending an *Introduction to Whole Health* and/or *Taking Charge of My Life & Health (TCMLH)* session. To offer these sessions, your site needs to provide specific resources as outlined below.

### ***Introduction to Whole Health***

Sites should offer at least two sessions a month.

#### **Management:**

- Identify Veteran peer facilitators to run the sessions. Facilitators can be Veteran employees or volunteers.
- Ensure that facilitators attend the *Introduction to Whole Health Facilitator Training*.
- Aim for your sessions to occur in a space that resembles a healing environment.
- Track attendance (i.e., date of session, number of attendees). The 2018 Executive Order requires you to report this information. To do so, use the Introduction to Whole Health Tracking form on the [Whole Health LEAF portal](https://leaf.va.gov/NATIONAL/10NE/Whole_Health/) ([https://leaf.va.gov/NATIONAL/10NE/Whole\\_Health/](https://leaf.va.gov/NATIONAL/10NE/Whole_Health/)).

#### **Facilitators:**

- Ensure mental health resources are available in the event that acute issues arise.
- Gather informational handouts for sessions.
- (Optional) Order training resources from OPCC&CT. Allow 2-3 weeks for delivery.

### ***Taking Charge of My Life & Health***

*TCMLH* programs can be completed individually, in a group, or with a WH partner.

#### **Management:**

- Identify three Veteran peers and one site supervisor to take the OPCC&CT *TCMLH Facilitator Training*.
- Plan the number of *TCMLH* sessions you can offer. Consider starting with one group a month.
- Aim for your *TCMLH* session to occur in a space that provides a healing environment.
- Confirm your site has incorporated Whole Health coding and tracking guidance.
- Plan your site's Whole Health referral and enrollment strategy.

#### **Supervisor:**

- Consult *TCMLH* curriculum for supplies needed and secure their availability.
- Plan your *TCMLH* program recruitment strategy.
- Establish guidelines for collaboration within and outside the VA, including facility-based resources (e.g., MOVE!) and community resources (e.g., local YMCA).

### 3.3 Checklist of Initial Whole Health Activities

#### OVERALL

- ☐ Identify at least one member of the organization's Executive Leadership Team as a Whole Health champion.
- ☐ Review position descriptions for key Whole Health roles (program manager, clinical director, education champions, and admin support) and discuss who at your site could perform these roles. (Refer to section 5. [Operations Domain](#) of this *Guide* for further information).
- ☐ Designate the primary Whole Health point of contact (POC).
- ☐ Engage in discussions with clinicians to determine who has experience or interest in Whole Health and/or Complementary and Integrative Health.
- ☐ Select/assign a site-based Whole Health clinical director.
- ☐ Identify clinicians who can serve as Whole Health clinical champions. These are individuals with a high level of motivation to implement, spread, and encourage others to adopt the practice of Whole Health within your site.
- ☐ Review samples of Whole Health Steering Committee Charters and organizational structures to help identify future committee members and infrastructure. (Refer to section 4. [Governance Domain](#) of this *Guide* for further information).

#### THE PATHWAY

##### *Selection and Training of Staff*

- ☐ Recruit Veteran peers or Whole Health partners or select volunteers to support the availability of *Introduction to Whole Health* sessions and *TCMLH*.
- ☐ Offer Veteran peers or Whole Health partners or volunteers training in the *Introduction to Whole Health Facilitator Training*, *TCMLH Facilitator Course* and/or *Whole Health Partner Training* as required for their role. (Refer to section 6. [Pathway Domain](#) of this *Guide* for further information).

##### *Preparing for Pathway Sessions*

- ☐ Plan how many and what type of *TCMLH* groups will be offered. Strive to offer one to four groups per month.
- ☐ Complete review of Whole Health materials available from OPCC&CT. Select and print brochures that support Pathway offerings. These materials are available on the [Communications page of the OPCC&CT SharePoint](#). (<https://dvagov.sharepoint.com/sites/VHAOPCC/sitepages/communication-resources.aspx>).
- ☐ Select a room that offers a healing environment and acquire necessary equipment (e.g., audiovisual, flipcharts, etc.).
- ☐ Create an internal/external communication plan to advertise Whole Health offerings and encourage enrollment and partnerships. (Refer to section 5. [Operations Domain](#) of this *Guide* for further information).
- ☐ Set up Clinic and CPRS Documentation/Coding to track metrics and accountability. (Refer to section 5. [Operations Domain](#) of this *Guide* for further information).

## WELL-BEING PROGRAMS

### *Selection of Programs*

- ☐ Review the required List 1 CIH approaches. (Refer to section 7. [Well-being Domain](#) of this *Guide* for further information)
- ☐ Conduct a needs assessment and solicit feedback from Veterans to determine what CIH services and Well-being classes to provide initially.
- ☐ Provide at least 2 CIH offerings initially to meet the Opioid Safety Initiative requirement under the 2016 CARA legislation.

### *Selection and Training of Staff*

- ☐ Survey staff for existing CIH skills and interests.
- ☐ Explore CIH provider job descriptions and recruit, repurpose or contract when feasible. (Refer to section 5. Operations Domain of this *Guide* for further information).
- ☐ Explore the Whole Health coach role and identify if there is an existing staff member who could work in both Well-being Programs and WH Clinical Care. (Refer to section 6. Pathway Domain of this *Guide* for further information).

### *Preparing for Well-being Programs*

- ☐ Complete review of Whole Health materials available from OPCC&CT. Select and print brochures that support Well-being offerings. These resources can be located in the [Communications section of the Whole Health Hub](#) (<https://dvagov.sharepoint.com/sites/VHAOPCC/sitepages/communication-resources.aspx>).
- ☐ Identify group, clinic and waiting rooms. Acquire necessary audiovisual and other equipment and storage space.
- ☐ Create an internal/external communication plan as well as marketing tools to advertise for enrollment and partnerships. (Refer to section 5. Operations Domain of this *Guide* for further information).
- ☐ Develop tracking mechanisms for Well-being Program services. (Refer to section 5. Operations Domain of this *Guide* for further information).

## WHOLE HEALTH CLINICAL CARE (WHCC)

### *Identifying WH Champions*

- ☐ Survey clinicians for existing skills and interests.
- ☐ Forge relationships with other programs, such as HPDP, Pain, HBC, Nutrition, Social Work, Patient Care Services, PCMHI, Mental Health, etc.
- ☐ Provide information on the WH Champion role and training resources to interested clinicians.

### *Preparing Resources for WHCC*

- ☐ Complete review of Whole Health materials available from OPCC&CT. Select and print brochures and other resources that support WH Clinical Care (PHIs, pocket cards, education handouts, etc). These resources can be located in the [Communications section of the Whole Health Hub](#) (<https://dvagov.sharepoint.com/sites/VHAOPCC/sitepages/communication-resources.aspx>).

- Acquire necessary Audiovisual equipment for waiting room videos and Star-Well DVDs.
- Develop documentation mechanisms for WH Clinical Care (Refer to sections 5. Operations Domain and 8. Whole Health Clinical Domain of this *Guide*).

#### *Selection and Training of Pilot Teams*

- Select clinical team(s) to pilot WH Clinical Care. (Primary Care is often the preferred starting point).
- Offer *Whole Health in Your Practice* and other appropriate Whole Health clinician training to pilot teams (Refer to section 8. Whole Health Clinical Domain of this *Guide* for further information).

### **EMPLOYEE WHOLE HEALTH**

- Designate the Employee Whole Health POC.
- Complete review of Employee Whole Health materials available from OPCC&CT on the [Employee Whole Health section of the Whole Health Hub](https://dvagov.sharepoint.com/sites/VHAOPCC/ewh) (<https://dvagov.sharepoint.com/sites/VHAOPCC/ewh>).

## 3.4 Planning for Success

It is critical to understand that this “quick start” chapter does *not* eliminate the need for the Whole Health program manager/coordinator to become thoroughly familiar with the *Designation Framework for Whole Health Implementation* and its companion online *Whole Health System Self-Assessment Tool*, as described below:

- The [Designation Framework for Whole Health Implementation](https://dvagov.sharepoint.com/:w:/s/VHAOPCC/EUdWEp9OfqtGt3wL4-VZ3mIBIRzn6chrEYAyqfc7fftDyW?e=flmsq5) (<https://dvagov.sharepoint.com/:w:/s/VHAOPCC/EUdWEp9OfqtGt3wL4-VZ3mIBIRzn6chrEYAyqfc7fftDyW?e=flmsq5>) **addresses the question, “Where are we going?”** by describing the future state when the Whole Health System is implemented. It describes desired outcomes along the four phases of the Whole Health implementation journey. To achieve these outcomes, key milestone accomplishments have been identified and organized around seven domains: Governance, Operations, Pathway, Well-being, Whole Health Clinical Care, Employee Whole Health, and Community Partnerships. It is important to note that the *Designation Framework* is **not intended** to prescribe exactly *how* a site achieves each accomplishment. Instead, the goal is to provide sites with latitude and flexibility in how they choose to operationalize Whole Health processes and practices.
- The [Whole Health System Self-Assessment Tool](https://vawww.whassessmenttool.va.gov/login/) (<https://vawww.whassessmenttool.va.gov/login/>) **addresses the question, “Are we there yet?”** Accomplishments from each phase of the *Designation Framework* have been transferred into this tool as discrete elements that can be scored individually. Intended for individual site use, the *WHS Self-Assessment Tool (WHSSAT)* can aid a site in identifying and organizing Whole Health initiatives and priorities.

**The combined use of these two key Whole Health implementation resources ultimately informs and shapes the path of a site’s Whole Health journey.** It also assures that all aspects of Whole Health (e.g., the seven domains outlined in the *Designation Framework* document) are fully

considered and included in the site's implementation plan. While it may be tempting to focus only on those domains that are most visible to Veterans (such as the Pathway, Well-being and WH Clinical Care domains), there are other domains that are equally, if not more important for future success and sustainment.

### 3.4.1 Importance of Governance and Operations Domains

**A number of activities residing within the Preparation and Foundational phases of the Governance and Operations domains are critical to successful Whole Health implementation and should not be overlooked.** For example, staffing plans must be developed that outline the types and numbers of Whole Health positions required. Staffing plans themselves must be based on a thoughtful determination of the types and location(s) of Whole Health services to be offered. The scope of services cannot be determined until the site has conducted a variety of environmental scans and needs assessments, followed by the creation of a Whole Health strategic plan. Whole Health workload cannot be accurately assessed until effective coding and tracking systems are set up. Position descriptions must be written, and staff recruited and trained.

**Furthermore, site leadership must be fully committed to the cultural transformation journey.** This is best accomplished by not only training leadership in Whole Health concepts, but ideally by also providing leadership with the opportunity to *experience* Whole Health personally to build “buy in.” Leaders who are “on board” with Whole Health will actively help remove barriers and smooth the path to full implementation.

**Sufficient work in the early phases of the Governance and Operations domains in particular is vital to setting the stage for future success. Without this foundation, pilot efforts implemented in other domains can easily stall out, and overall progress may be hindered.**

In short, sites are urged to take a comprehensive approach to local Whole Health implementation planning and to utilize the *Designation Framework for Whole Health Implementation* and online *WHS Self-Assessment Tool* to navigate the process. In addition, this implementation *Guide* provides information and examples of how the various *Designation Framework* accomplishments could be met.

Remember, too, that OPCC&CT FIT Consultants are available to assist sites in conducting gap analyses using these tools, and then in developing site-specific project plans/strategic plans to guide local Whole Health implementation efforts. Refer to section [11. Evaluating Whole Health Implementation](#) of this *Guide* for further information about Whole Health evaluation efforts.

## 4. Governance Domain

Governance is a crucial domain demanding an organization's attention if it wants to increase the likelihood of successful and sustained implementation of the Whole Health System (WHS) in a transformed, patient-centric culture. Not only does the organization hardwire the necessary oversight body for the implementation steps, but it also provides accountability for sustained change, quality outcomes, and engaged leadership. Organizations that have been able to move forward in multiple domains of the *Designation Framework* have intentionally ensured the governance has been addressed first, and that it is soundly in place in the Foundational Phase.

This chapter includes discussions of the characteristics and particulars of Whole Health (WH) governance across the four phases of the implementation journey.

**As a supplement to the material presented in the remainder of this chapter, please refer to the [overview of Governance Domain activities](https://dvagov.sharepoint.com/w:/r/sites/VHAOPCC/WH-Implementation/_layouts/15/Doc.aspx?sourcedoc=%7B1A46734F-DB9E-4E99-8046-1A77E3081480%7D&file=Governance_Domain_Overview_Chart_with_Links.docx&wdLOR=cDB801427-1838-4530-AA46-D3D4DD066C2D&action=default&mobileredirect=true)** ([https://dvagov.sharepoint.com/w:/r/sites/VHAOPCC/WH-Implementation/\\_layouts/15/Doc.aspx?sourcedoc=%7B1A46734F-DB9E-4E99-8046-1A77E3081480%7D&file=Governance\\_Domain\\_Overview\\_Chart\\_with\\_Links.docx&wdLOR=cDB801427-1838-4530-AA46-D3D4DD066C2D&action=default&mobileredirect=true](https://dvagov.sharepoint.com/w:/r/sites/VHAOPCC/WH-Implementation/_layouts/15/Doc.aspx?sourcedoc=%7B1A46734F-DB9E-4E99-8046-1A77E3081480%7D&file=Governance_Domain_Overview_Chart_with_Links.docx&wdLOR=cDB801427-1838-4530-AA46-D3D4DD066C2D&action=default&mobileredirect=true)), **which includes links to corresponding available resources.**

### 4.1 Governance in the Preparation Phase

The **Preparation Phase of the Governance domain focuses on planning a governance structure tailored to the organization's culture** that will represent the authority that will guide decision-making to support change to a patient-centered, Whole Health culture.

#### Questions to consider in the Preparation Phase:

- Who are the individuals to best plan for the oversight and accountability for Whole Health implementation in this organization?
- Which senior leader from the organization is motivated, has an interest, and/or is best suited to champion and remain engaged in Whole Health oversight and accountability?
- How will the Veteran voice be included at this point of planning? Is there an existing Patient Family Advisory Committee (PFAC) or process for including the Veteran voice in this organization? How will we include a Veteran as part of the Whole Health governance entity?
- What type of organizational structure might work best to provide oversight and accountability in this organization? Will this require a new committee to be established or might it be best to integrate into an existing committee?
- Are those responsible for Whole Health implementation aware of the Office of Patient Centered Care and Cultural Transformation (OPCC&CT) [Whole Health Hub](https://dvagov.sharepoint.com/sites/VHAOPCC/sitepages/index.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/sitepages/index.aspx>) containing resources to support Whole Health implementation, including the Governance Domain, and are they in communication with the assigned Field Implementation Team (FIT) consultant?



Reminder: As a supplement to the material presented in this section, please refer to the [overview of Governance Domain activities](https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/WH-Implementation/_layouts/15/Doc.aspx?sourcedoc=%7B1A46734F-DB9E-4E99-8046-1A77E3081480%7D&file=Governance_Domain_Overview_Chart_with_Links.docx&wdLOR=cDB801427-1838-4530-AA46-D3D4DD066C2D&action=default&mobileredirect=true) (https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/WH-Implementation/\_layouts/15/Doc.aspx?sourcedoc=%7B1A46734F-DB9E-4E99-8046-1A77E3081480%7D&file=Governance\_Domain\_Overview\_Chart\_with\_Links.docx&wdLOR=cDB801427-1838-4530-AA46-D3D4DD066C2D&action=default&mobileredirect=true), which includes links to corresponding available resources.

#### 4.1.1 Structure for Whole Health Oversight and Accountability (G.1.2, 1.2, 1.3, 1.5)

**In this phase, the organization is actively planning and engaging to design the Whole Health governance structure.** This includes designing the structure itself and the development of intentional milestones ranging from initial implementation of core Whole Health offerings to expansion of efforts beyond initial start-up. The effort may be driven primarily by a limited number of Whole Health champions from the organization AND requires the support of a senior leader within the organization as well as input from Veteran stakeholders. These Whole Health pioneers will need to come together to discuss and plan for the governance structure that will manage Whole Health implementation. The aim is to define how Whole Health transformation will be planned, resourced, managed and measured to ensure change makes sense for the organization, is relevant, and can be sustained over time.

#### 4.1.2 Determining the Whole Health Governance Structure (G.1.3)

The governing structure for Whole Health should be reflective of the current culture and must be clearly defined by the organization. This governance structure can manifest as a new committee, or the functions associated with oversight can be integrated into an existing committee, such as an Organizational Health Committee, Organizational Improvement Council, or another workgroup within an existing structure. Whatever the decision, the structure should be highly visible and regarded by the organization and have a means for connecting to and sharing information with Executive Leadership.

#### 4.1.3 Membership (G.1.1, 1.2, 1.5, 1.6)

Most likely, one or more persons will be given the responsibility for initiating activities for Whole Health implementation. Although a full-time employee (FTE) is ideal, there are varying approaches (collateral duty, details, etc.) to protect substantial amounts of time for staff charged with leading Whole Health implementation efforts. Whole Health transformation is a team effort and requires concrete activities to make it a reality, which relies on dedicated staff time for success.

**Change management theory emphasizes the support of one or more executive leaders (executive sponsorship) to increase the likelihood of successful implementation** of any initiative. This leader should be, at minimum, an active member of the Whole Health governing body and ideally function as chair or co-chair of such an entity. The role of the executive leader [Sponsor] includes being visible in the activities of Whole Health implementation; building coalitions in the organization to support Whole Health implementation; and direct communication with staff, Veterans, and other key stakeholders regarding Whole Health implementation.

It is essential that the organization identify one or more Whole Health champions from major services or product lines (both clinical and administrative) to facilitate Whole Health adoption. At minimum, membership on the Whole Health governance entity should include Whole Health champions from Primary Care/PACT, Mental Health and Nursing. However, comprehensive representation from all major

clinical and administrative services, even if it is ad hoc, should participate. There are many service lines or programs within your site that offer natural partnership opportunities. **The list below is not exhaustive, but offers likely areas where fellow Whole Health champions and allies may be found.**

- Health Promotion and Disease Prevention Coordinator (HPDP)
- MOVE! Coordinator
- Health Behavior Coordinator (HBC)
- Health and Wellness Coaches
- Veteran Health Education Coordinator
- Primary Care/Patient Aligned Care Team (PACT)
- Primary Care Mental Health Integration (PCMHI)
- Substance Abuse Residential Rehabilitation Treatment Program (SAARTP)
- Pain Management Teams
- Patient Advocates/Veteran Experience Officer
- Physical Medicine and Rehabilitation (PMR)
- Medicine
- Surgery/Anesthesia
- Employee Health and Well-being
- Quality Management
- Social Work Services
- Nutrition
- Pharmacy
- Mental Health
- Peer Support Specialists
- Nursing Service
- Chaplain Service

**Last, but not least, Veteran representation on the governance entity is vital.** The Veteran representative should be carefully selected and, ideally, be a recipient of services. The organization should explore options for recruitment of one or more Veteran representative(s) to the governance entity to maximize the value and minimize the potential of conflicting motives for participation. In some circumstances, Veteran employees such as Peer Specialists and other Veteran staff have been assigned membership as part of their duties to fulfill this need. This is an option, but do not discount the value of having a Veteran who uses the system as an objective participant. Veteran Advisors or a Patient and Family Advisory Council (if it exists in the organization) can be a good source for recruitment.

#### 4.1.4 Drafting the Charter and Defining the Functions of the Whole Health Governance Structure (G.1.4, 1.7, 1.8, 1.9, 1.10)

Regardless of how Whole Health governance is structured (committee, council, sub-group of another council, etc.), it is important that the membership, purpose, meeting frequency and expectations, and key functions are defined and documented in a manner that makes sense to the organization. This information can be captured in a committee policy, standard operating procedure (SOP) document, or in a Committee/Workgroup Charter.

The functions of the governance entity are informed by the specific needs of the organization that minimally includes:

- Regular assessment of implementation reflective of the *Designation Framework* Domains and Phases
- An environmental scan and needs assessment leading to the organization's Whole Health Strategic Plan
- A plan to regularly track and monitor Whole Health utilization, cost data, and outcomes

The organization is encouraged to consider how to integrate Whole Health with existing programs, services, partners and stakeholders (e.g., Healthy Living Teams, PACT, Mental Health, Social Work, Public Affairs, and Nursing, etc.).

## 4.2 Governance in the Foundational Phase

### Questions to Consider in the Foundational Phase:

- Does the charter include parameters or guidance regarding expectations, funding and/or restrictions from the senior leadership team that will define the scope of Whole Health from which the governance entity can make decisions?
- Will the meetings have virtual options for membership to participate?
- How will the administrative needs (meeting invitations, agenda, minutes, etc.) of the governance entity be met?
- Is the governance entity aware of data mechanisms in place (WH Dashboard, Health Factors, Time in Program reports) to support Whole Health tracking? Is orientation needed?
- Is the governance entity meeting and functioning as conceptualized, or do adjustments need to be made?
- Is the executive sponsor visible, supporting coalition building, and communicating information regarding Whole Health implementation with key stakeholders?

Reminder: As a supplement to the material presented in this section, please refer to the overview of [Governance Domain activities](https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/WH-Implementation/_layouts/15/Doc.aspx?sourcedoc=%7B1A46734F-DB9E-4E99-8046-1A77E3081480%7D&file=Governance_Domain_Overview_Chart_with_Links.docx&wdLOR=c8FC5CF5E-FF8A-418C-841D-43D27B86FF28&action=default&mobileredirect=true) (https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/WH-Implementation/\_layouts/15/Doc.aspx?sourcedoc=%7B1A46734F-DB9E-4E99-8046-1A77E3081480%7D&file=Governance\_Domain\_Overview\_Chart\_with\_Links.docx&wdLOR=c8FC5CF5E-FF8A-418C-841D-43D27B86FF28&action=default&mobileredirect=true), which includes links to corresponding available resources.

### 4.2.1 Leading Change (G.2.1, 2.2, 2.4, 2.5, 2.6)

**Careful thought should be given to those assigned responsibility for Whole Health implementation and its oversight to ensure successful and sustained change.** The 18 Flagship Sites that piloted implementation of the Whole Health System were charged with designating a Whole Health program manager and clinical director to lead Whole Health implementation efforts. These dedicated FTEs were instrumental in sustaining change at those sites. If the organization is able, funding one or more of these Whole Health staff is advantageous. In the absence of such resources, designated time commensurate with the scope of the organization's Whole Health vision is strongly recommended, typically >0.5 FTE.

The Executive Leadership Team (ELT) and other senior leaders within the organization should complete a formal Whole Health learning activity with an experiential component. Your FIT consultant can assist with determining which educational option might be most appropriate and best fit the needs of the organization. There are several options available as described on the [OPCC&CT Education SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Home.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Home.aspx>). As part of succession planning, the organization will define how new, future leaders will be oriented to Whole Health concepts inclusive of an experiential component, and document the process in a Whole Health SOP, orientation policy, or other document.

The site's major and ancillary patient care-related service/product lines are represented in Whole Health implementation efforts by at least one liaison/champion to facilitate the spread of Whole Health and the development and implementation of supportive processes.

#### 4.2.2 Operationalizing the WH Governance Entity (G.2.7, 2.8, 2.9, 2.10, 2.11, 2.12)

The document (e.g., charter, policy) containing the specifics of Whole Health implementation, oversight and accountability is now finalized and signed by the leadership team in accordance with the organization's routine approval process. Additionally, the organization has a documented plan for Whole Health implementation, which can be a separate plan or integrated into the organization's overall strategic plan (preferred). Persons responsible for initiating or leading Whole Health implementation activities as well as the Whole Health governance membership can easily access the documented plan.

The Whole Health governance entity is meeting according to the charter (at least quarterly). Membership and attendance is monitored and includes the ELT sponsor, WH champion(s) and Veteran representation.

Agenda items include but are not limited to:

- Planning Whole Health activities to accomplish objectives of the organization's Whole Health strategic plan
- Whole Health Education activities
- Whole Health Communication Plan
- Monitoring implementation activities of the organization's Whole Health strategic plan
- Addressing barriers to Whole Health implementation
- Monitoring Whole Health utilization, cost data, clinical outcomes, and other measurement deemed important to the organization
- Discussing mechanisms to incorporate broader Veteran input

### 4.3 Governance in the Developmental Phase

A sustain and spread approach has taken root in the Whole Health governance structure and has moved throughout the organization. The Whole Health infrastructure is actively expanding staffing, systems and offerings to meet Veteran demand.

#### Questions to consider in the Developmental Phase:

- How has Whole Health expanded beyond Primary Care or other originating service line?
- What is the plan for continued expansion?

- Are Whole Health utilization data appearing in the Whole Health Dashboard and Health Factors report?
- Are the data deemed important during the previous phases routinely shared and discussed at meetings?
- How can the organization better integrate Whole Health into existing organizational structures that are working well and effectively?
- Does the organization already have mechanisms to incorporate Veteran perspectives, such as, but not limited to regular and systematic review of robust and well-defined sources of Veteran input, Veteran advisor participation on key committees, a strong partnership with an independent Veteran Council operating within the organization, and/or an engaged Patient and Family Advisory Committee (PFAC) or equivalent group

Reminder: As a supplement to the material presented in this section, please refer to the [overview of Governance Domain activities](https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/WH-Implementation/_layouts/15/Doc.aspx?sourcedoc=%7B1A46734F-DB9E-4E99-8046-1A77E3081480%7D&file=Governance_Domain_Overview_Chart_with_Links.docx&wdLOR=cDB801427-1838-4530-AA46-D3D4DD066C2D&action=default&mobileredirect=true) (https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/WH-Implementation/\_layouts/15/Doc.aspx?sourcedoc=%7B1A46734F-DB9E-4E99-8046-1A77E3081480%7D&file=Governance\_Domain\_Overview\_Chart\_with\_Links.docx&wdLOR=cDB801427-1838-4530-AA46-D3D4DD066C2D&action=default&mobileredirect=true), which includes links to corresponding available resources.

#### 4.3.1 Maturing the Governance Infrastructure (G.3.2, 3.3, 3.4, 3.7)

The Governance structure is established and meeting according to the set schedule – weekly, monthly but at minimum quarterly - with representation from a broad range of clinical and administrative service lines. Veteran representation has expanded beyond initial efforts. If Whole Health champions have not been widely identified at this point, it can be helpful to:

- Ask leadership to assist with building coalitions with services and product lines
- Identify enthusiastic participants in classes provided, e.g. WH 102 or 202; and/or
- Incorporate good news stories into newsletters, blogs, staff meetings and announce opportunities to participate

All members of the governance entity and senior leadership should attend a Whole Health education session that includes an experiential component, such as WH 102 or 202 educational course. The assigned OPCC&CT FIT consultant can assist in identifying appropriate educational opportunities.

#### 4.3.2 Maturing Governance Functions (G.3.1, 3.6, 3.9)

Governance functions are maturing in the Developmental Phase with intention to integrate Whole Health throughout the organization. The Whole Health infrastructure is participating in decision-making and actively expanding staffing, systems and programmatic elements and services to meet Veteran demand.

Governance is routinely collecting and reviewing data in accordance with implementation and measurement plans in place, as well as completing reassessments and adjusting Whole Health implementation planning and actions. It can be helpful to use a standardized agenda to ensure functions are happening according to the entity's specified timeline.

#### 4.3.3 Incorporating Veteran Input (G.3.7, 3.8)

**Veteran representation on the committee is vital.** Many organizations have found it beneficial to identify Veteran advisors who are using the VA health care system to fill this role, while others have decided to include employees who are Veterans or a combination of both. Of course, one or a few members cannot speak for all Veterans using the services of the organization, so it is important to include other mechanisms to provide input, e.g. HCAHPS data, town halls, focus groups, trended complaint data, and/or information provided from patient advocates or Veteran Service Organizations. Veteran representatives can also be embedded into other medical center committees, task forces, special project teams, and strategic planning sessions to solicit broader and more regular Veteran feedback into the organization's decision-making process. The existence of an independent Veteran Council within the healthcare system, if any, offers opportunities for collaboration and partnership. Such councils might be found within local Mental Health recovery programs, and have been known to expand their focus to represent Veterans beyond those receiving Mental Health services.

If the organization is open to forming a Patient and Family Advisory Council, refer to the [Voice of the Veteran Family Advisory Council Toolkit](https://dvagov.sharepoint.com/:f:/r/sites/VHAOPCC/Innovations/ToolkitsProjectOverviews/Toolkit%20--%20Voice%20of%20the%20Veteran-Family%20Advisor%20Council?csf=1&web=1&e=xessgB) (<https://dvagov.sharepoint.com/:f:/r/sites/VHAOPCC/Innovations/ToolkitsProjectOverviews/Toolkit%20--%20Voice%20of%20the%20Veteran-Family%20Advisor%20Council?csf=1&web=1&e=xessgB>) for assistance.

#### 4.4 Governance in the Full Phase

In the Full Phase, the organization can point to evidence or documentation that a complete and effective Governance Whole Health structure is in operation within the organization. Reliable processes, resources, space and staff are in place to consistently deliver a Whole Health approach to Veterans engaged in all services in a healing environment and through healing relationships.

##### Questions to consider in the Full Phase:

- What documents, examples, or other evidence exists to communicate that Whole Health has taken root in the organization?
- What documents, examples, or other evidence exists to communicate that Veterans have widespread and meaningful participation, input, and influence into organizational decision making and strategic planning?
- Is Whole Health regarded as an organizational priority with documented goals in its strategic planning documents?
- In alignment with the organization's Whole Health vision and strategic plan, are all identified areas delivering Whole Health?
- What is the plan for sustainment?

Reminder: As a supplement to the material presented in this section, please refer to the [overview of Governance Domain activities](https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/WH-Implementation/_layouts/15/Doc.aspx?sourcedoc=%7B1A46734F-DB9E-4E99-8046-1A77E3081480%7D&file=Governance_Domain_Overview_Chart_with_Links.docx&wdLOR=cDB801427-1838-4530-AA46-D3D4DD066C2D&action=default&mobileredirect=true) ([https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/WH-Implementation/\\_layouts/15/Doc.aspx?sourcedoc=%7B1A46734F-DB9E-4E99-8046-1A77E3081480%7D&file=Governance\\_Domain\\_Overview\\_Chart\\_with\\_Links.docx&wdLOR=cDB801427-1838-4530-AA46-D3D4DD066C2D&action=default&mobileredirect=true](https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/WH-Implementation/_layouts/15/Doc.aspx?sourcedoc=%7B1A46734F-DB9E-4E99-8046-1A77E3081480%7D&file=Governance_Domain_Overview_Chart_with_Links.docx&wdLOR=cDB801427-1838-4530-AA46-D3D4DD066C2D&action=default&mobileredirect=true)), which includes links to corresponding available resources.

#### 4.4.1 Sustained Governance Infrastructure (G.4.1, 4.2, 4.7)

The Whole Health governance entity is regularly meeting now with active participation from its members, inclusive of the Executive Leader or Sponsor and Veteran representative(s). Meeting minutes are kept reflecting attendance, topics, review and evaluation of data, decision-making and actions undertaken by the team. Continued implementation, sustainment, and integration of Whole Health across the organization are a focus of the team with accomplishments and opportunities for further development identified and shared across the organization.

**In full implementation phase, Whole Health should not only be a topic of conversation within the committee, workgroup or entity assigned to monitor Whole Health implementation, but also referenced in relevant\*:**

- Key policies (e.g. Committee Policy, Employee Health)
- Documents (e.g. Strategic Plan, SOPs)
- Discussion and/or minutes of other committees (e.g. Executive Committee of the Governing Body, Performance Improvement/Quality Council, Medical Staff Committee and/or others)
- Workgroups (e.g. Improvement Teams, Wellness Team)
- Service-line meetings (clinical and administrative)
- Organization-wide events (e.g. Town Halls, WH Month, Nurses' Week, Health Fair).

*\* The examples provided are not prescriptive or all-inclusive and will differ depending on the organization and the scope of Whole Health undertaken by the organization.*

#### 4.4.2 Executive Leadership Engagement (G.4.3, 4.4, 4.5, 4.6, 4.8, 4.14)

The ELT and other senior leaders within the organization have attended initial Whole Health training (inclusive of an experiential component), and a commitment for continued education for leadership to remain informed and knowledgeable of Whole Health concepts, principles, and best practices is evident.

The integration of Whole Health has been documented and incorporated into the onboarding process for new leaders to ensure continuity through leadership turnover.

The ELT is knowledgeable of the Whole Health Strategic Plan and actively reinforces Whole Health goals through visible actions in support of Whole Health activities, the building of coalitions within the organization (and potentially the community), and in their direct communications with staff, Veterans and the community. Whole Health is considered when making decisions impacting the organization and is reflected in the minutes of meetings (e.g. Resource Committee, Human Resources, Strategic Planning, etc.).

#### 4.4.3 WH Measurement and Evaluation (G.4.9, 4.10, 4.11, 4.12, 4.13)

Data collection and analysis are documented functions of the Whole Health Governance entity. Organizational goals have been linked to a measure(s) of success with a detailed plan on what data will be collected, how data is compiled and aggregated, and assigned responsibility for all aspects. Veteran and employee feedback on value, satisfaction and demand for Whole Health services as well as Whole Health utilization are tracked to inform resource decisions. Outcome measure data/results, participation, satisfaction rates, and other inputs as appropriate drive performance improvement activities and influence decisions regarding Whole Health offerings and approaches. Consideration of



Whole Health data analysis can be found in meeting minutes and/or other documentation of decisions impacting Whole Health.

## 4.5 Role of the Network Sponsor

The Whole Health Network Sponsor (NS) is the network-level champion for Whole Health in the VISN and serves as the main network-level point of contact to OPCC&CT for the VISN. The NS supports efforts to align and integrate Whole Health implementation at all sites in the network to support National and VISN Whole Health priorities. This includes the development and oversight of a VISN Whole Health strategic plan. As such, each site's Whole Health governing entity should work closely with its NS when establishing the local strategic plan and direction for Whole Health at the facility. For more information about the Network Sponsor role, refer to [Network Sponsor Expectations](https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/WH-Implementation/Governance_Domain/WH_Network_Sponsor_Expectations.docx?d=wee6491a949294852baff953a9334e48f&csf=1&web=1&e=EGWCiD) (https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/WH-Implementation/Governance\_Domain/WH\_Network\_Sponsor\_Expectations.docx?d=wee6491a949294852baff953a9334e48f&csf=1&web=1&e=EGWCiD).

### Resources:

[Governance Domain SharePoint Document Library](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Governance_Domain/Forms/AllItems.aspx) (https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Governance\_Domain/Forms/AllItems.aspx)

### [Overview of the Governance Domain activities](https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/WH-Implementation/_layouts/15/Doc.aspx?sourcedoc=%7B1A46734F-DB9E-4E99-8046-1A77E3081480%7D&file=Governance_Domain_Overview_Chart_with_Links.docx&wdLOR=c0AB90BC3-66B3-418B-B07F-872619E87EC8&action=default&mobileredirect=true)

(https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/WH-Implementation/\_layouts/15/Doc.aspx?sourcedoc=%7B1A46734F-DB9E-4E99-8046-1A77E3081480%7D&file=Governance\_Domain\_Overview\_Chart\_with\_Links.docx&wdLOR=c0AB90BC3-66B3-418B-B07F-872619E87EC8&action=default&mobileredirect=true)

### [Other Governance-Related Toolkits/Project Overviews](https://dvagov.sharepoint.com/sites/VHAOPCC/Innovations/ToolkitsProjectOverviews/Forms/AllItems.aspx?viewid=94be29e6%2D14ac%2D4442%2Db341%2D74b659991369&id=%2Fsites%2FVHAOPCC%2FInnovations%2FToolkitsProjectOverviews)

(https://dvagov.sharepoint.com/sites/VHAOPCC/Innovations/ToolkitsProjectOverviews/Forms/AllItems.aspx?viewid=94be29e6%2D14ac%2D4442%2Db341%2D74b659991369&id=%2Fsites%2FVHAOPCC%2FInnovations%2FToolkitsProjectOverviews). This is collection of previous OPCC&CT innovations grant summaries, including programming ideas that are related to Whole Health governance, such as:

- Governance Structure Toolkit
- Veteran/Family Advisory Council
- And more



## 5. Operations Domain

**The Operations Domain encompasses the infrastructure and processes necessary to fully support the Whole Health (WH) activities taking place in the other domains.** These include Veteran outreach, staff planning (hiring, recruitment and credentialing), staff and volunteer training in Whole Health, space planning, communications, and documentation.

### 5.1 Veteran Outreach

Outreach can take many forms. Many Veterans we serve are members of Veteran Service Organizations (VSO) and other community organizations. VA Medical Centers may already have established relationships with their local VSOs and other community organizations, and these relationships are critical to educate their membership and staff to drive demand for Whole Health services.

Optimizing health and well-being is precisely the goal of helping Veterans reach--and live--what they consider to be their “best life.” To accomplish this, we need to purposefully reach out to Veterans via various mechanisms that appeal to the different generations of Veterans to engage them in Whole Health. This purposeful outreach will include technological and conventional methods as well as a social media presence as described in the sections below. In addition, [OPCC&CT’s Whole Health Outreach Toolkit](https://www.va.gov/WHOLEHEALTH/get-involved/outreach-toolkit.asp) (<https://www.va.gov/WHOLEHEALTH/get-involved/outreach-toolkit.asp>) is another valuable tool.

#### 5.1.1 Technological Methods

##### 5.1.1.1 Whole Health Apps

The ***Live Whole Health smartphone application***, developed by OPCC&CT, offers a way for Veterans to check in on their health and life goals from the palm of their hand. It is another tool in exploring what users want from their health and why, for advancing Veteran engagement, and helping to build healthy habits that promote well-being. The app guides the user through the Personal Health Inventory (PHI) and the Circle of Health, uses videos to provide education, and facilitates goal setting to begin to develop a Personal Health Plan (PHP). The app can be used independently or along with a Whole Health partner or coach. The *Live Whole Health app* is currently available for download from the Google Play Store and the Apple App Store. In addition, it is also available in the VA App Store.

There are many other mobile applications for Veterans that support well-being. A comprehensive list of such VA-developed applications is available at the [VA App Store for Veterans](https://mobile.va.gov/appstore/veterans) (<https://mobile.va.gov/appstore/veterans>). In addition, the Integrative Health Coordinating Center (IHCC) has vetted many publicly available mobile solutions for Veterans to experience yoga, Tai Chi, biofeedback, and meditation approaches. These can be found on the [OPCC&CT Mobile Apps-Online Tools page](https://www.va.gov/WHOLEHEALTH/veteran-resources/MobileApps-OnlineTools.asp) (<https://www.va.gov/WHOLEHEALTH/veteran-resources/MobileApps-OnlineTools.asp>).

##### 5.1.1.2 Telehealth

Telehealth has emerged as a key platform for healthcare delivery, especially during the COVID-19 Pandemic. The vision of [VHA Telehealth Services](http://vawww.telehealth.va.gov/index.asp) (<http://vawww.telehealth.va.gov/index.asp>) is to improve quality, convenience, and access to care for Veterans through digital channels.

Given its value, it is **important to consider how best to utilize telehealth technology in the delivery of Whole Health to meet your site's and population's needs**. If there are Whole Health offerings that can be delivered to Veterans via telehealth technology, consider partnering with your local Facility Telehealth Coordinator to determine clinic setup, emergency/risk management procedures, and documentation, as these may vary by facility. The OPCC&CT is working with the National Office of Telehealth to create guidance on the development and implementation of TeleWholeHealth programming.

Helpful **Telehealth resources include:**

- [VHA TeleHealth intranet site](http://vaww.telehealth.va.gov/index.asp) (<http://vaww.telehealth.va.gov/index.asp>)
- [OPCC&CT TeleWholeHealth Resource Center](http://vaww.telehealth.va.gov/clinic/twhlt/index.asp) (<http://vaww.telehealth.va.gov/clinic/twhlt/index.asp>)
- [“Delivering Whole Health Pathway and Coaching Services Virtually” website](https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/WH-Position-Resources.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/WH-Position-Resources.aspx>). This site includes toolkits for offering successful virtual sessions, as well as a *Whole Health VA Video Connect Field Guide*
- [VA Video Connect home page](http://vaww.telehealth.va.gov/pgm/vvc/index.asp) (<http://vaww.telehealth.va.gov/pgm/vvc/index.asp>)
- [National Telehealth Technology Help Desk](https://vaww.infoshare.va.gov/sites/telehelpdesk/default.aspx) (<https://vaww.infoshare.va.gov/sites/telehelpdesk/default.aspx>)
- [VA Video Connect for Providers](https://vaww.telehealth.va.gov/roles/prvdr/vvc/index.asp) (<https://vaww.telehealth.va.gov/roles/prvdr/vvc/index.asp>)
- [VA Video Connect Promotional Materials](https://vaww.connectedhealth.va.gov/Communications/SitePages/toolkit-view.aspx?appName=va-video-connect) (<https://vaww.connectedhealth.va.gov/Communications/SitePages/toolkit-view.aspx?appName=va-video-connect>)

The goal is to endorse enterprise-wide telehealth solutions like VA Video Connect (VVC) and Clinical Video Telehealth (CVT) because they are the most secure.

#### *5.1.1.3 Internet and Social Media*

A presence on social media outlets (Facebook, Instagram, etc.) may attract new Veteran users to seek Whole Health care at area facilities or to use the *Live Whole Health App* or the [VA Whole Health internet](https://www.va.gov/WHOLEHEALTH/) (<https://www.va.gov/WHOLEHEALTH/>). Veterans that navigate to the VA Whole Health internet site will find various resources that include videos, the PHI, and other tools designed to increase understanding of the basics of Whole Health and to encourage users to begin their own self-care journey. The [#LiveWholeHealth blog](https://www.blogs.va.gov/VAntage/tag/livewholehealth/) (<https://www.blogs.va.gov/VAntage/tag/livewholehealth/>) is another valuable Veteran-facing resource offering experiential videos and content on a variety of self-care topics.

Your site may consider creating an online Whole Health presence on your webpage in collaboration with your local Information Technology department, network administrators, and ADPAC. It is important to determine who will manage the website and what content should be included (e.g., recordings of guided meditation, information about Whole Health programming, or cancellations of services and classes).

Refer to section [5.6 Communications and Advertising](#) for further information about maximizing the use of the internet and social media to promote Whole Health.

### 5.1.2 Conventional Methods

**Two conventional methods for conducting Veteran outreach include establishing a partnership with the Post-9/11 Military2VA Case Management program and hosting Whole Health fairs.** A collaborative partnership with Post-9/11 Military2VA Case Management teams will allow outreach to Veterans newly separating from service or those who are in the initial phases of transition. In addition, Whole Health information and materials can be offered at both internal and external fairs to attract new Veterans. Local VA facilities can target VSO and other community organization gatherings and similar events where such a presence could be beneficial.

## 5.2 Staffing

As a Whole Health System (WHS) is designed, a staffing plan to support the implementation of a Whole Health approach should be developed. A key first step in staffing is to perform a needs assessment and gap analysis. This evaluation and analysis of current and future states can be performed with assistance from your FIT Consultant and by utilizing available resources to include the [online WHS Self-Assessment Tool](http://vawww.whsassessmenttool.va.gov/) (<http://vawww.whsassessmenttool.va.gov/>). The results of this gap analysis will aid in the development of a staffing plan that can be achieved either through hiring all at once or incrementally, based on site goals and preferences. **A variety of approaches can be taken when filling Whole Health roles, including the use of permanent or temporary FTE, contractors, Without Compensation (WOC) staff and other volunteers, Memorandums of Understanding (MOUs), etc.** Each of these approaches is described in more detail in the [Hiring Whole Health Service Providers guidance document](https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/WH-Implementation/Operations_Domain/Hiring_WH_Service_Providers.docx?d=w1c7ba61937264f1f8e596c29b364b012&csf=1&web=1&e=TYLk2Z) ([https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/WH-Implementation/Operations\\_Domain/Hiring\\_WH\\_Service\\_Providers.docx?d=w1c7ba61937264f1f8e596c29b364b012&csf=1&web=1&e=TYLk2Z](https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/WH-Implementation/Operations_Domain/Hiring_WH_Service_Providers.docx?d=w1c7ba61937264f1f8e596c29b364b012&csf=1&web=1&e=TYLk2Z)).

Key and supporting Whole Health roles are both needed for success. Roles that drive early work include:

- Whole Health clinical director
- Whole Health program manager
- Administrative support

Additional roles include:

- Whole Health partners
- Whole Health coaches
- Whole Health mentors
- Complementary and Integrative Health (CIH) providers
- Whole Health clinical champions
- Whole Health facility education champions
- Medical support assistants (MSAs)
- Clinic coordinator
- Research assistants (as needed)
- Whole Health volunteers

As roles are put in place for Whole Health, use the [Whole Health Person Class Taxonomies guidance](https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/WH-) (<https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/WH->

Implementation/Operations\_Domain/Coding/Relevant\_WH\_Person\_Class\_Taxonomies.docx?d=wb7dc3064db540ed86f68a35d790200a&csf=1&web=1&e=4Cv19g) to ensure that the relevant taxonomies have been established for all Whole Health staff. The following subsections provide more information on various key and supporting roles for Whole Health implementation.

Processes for recruitment of key Whole Health roles from both internal and external sources should be developed early. Development of a plan to address number of staff needed, scope of practice, development of core competencies, training/mentorship, and supervision will be required for all Whole Health roles, with keen attention to unique positions such as Whole Health partners, Whole Health coaches, and Whole Health volunteers. Development of plans and processes for staffing should be conducted through the governance structure developed locally and, as desired, in consultation and support of your FIT Consultant. As Whole Health expands throughout the local system, periodic reevaluation of staffing and partnerships should be undertaken to ensure that staffing is sufficient to meet demand.

### 5.2.1 Key Roles for Whole Health

It is essential to select committed, passionate leaders able to negotiate support for Whole Health and forge agreements across different stakeholder groups within and external to the VHA. By advancing the concepts and vision of the Whole Health System, these leaders described in the following table will be instrumental in leading change, motivating colleagues, and coordinating Whole Health implementation.

*Table 1: Whole Health Leadership Roles*

Role	Responsibility
<b>Clinical director</b>	A provider (e.g., physician, nurse, psychologist, or other clinical leader) knowledgeable in Integrative Medicine, Whole Health, and clinical care who leads the transformational approach to a Whole Health System of care.
<b>Clinical champions</b>	Experts in Whole Health with a high level of motivation to implement, spread, and encourage others to adopt the practice of Whole Health within the VHA.
<b>Facility education champions</b>	One MD or Doctor of Osteopathy and one CIH professional (e.g., Holistic Nurse, Clinical Psychologist, Master of Social Work) who will offer ongoing training at the site.
<b>Program manager</b>	A site leader who manages the program staff, provides strategic direction, interfaces with leadership at the site, and manages the day-to-day operations of the program.
<b>Executive Leadership Team (ELT) Sponsor</b>	Executive level lead that oversees Whole Health and participates in site, VISN and Network Whole Health strategic planning.

Once you have a governance structure and key roles in place, you will determine additional staffing needs that support Whole Health implementation, including level of effort and role. These secondary or supportive Whole Health roles are also critical to success. When considering these roles, it is recommended to hire staff that can support multiple types of responsibilities (e.g., a blend of

administrative and clinical support). Based on learned experiences from the Whole Health Flagship Sites, recommended support roles are described in the following table:

*Table 2: Whole Health Support Roles*

Role	Responsibility
<b>Medical Support Assistant (MSA)</b>	Checks Veterans in/out as they attend groups, schedules appointments, and manages incoming consults.
<b>Whole Health mentor</b>	Plays a critical role in advancing Whole Health by ensuring fidelity and quality of Whole Health services. Provides ongoing skill training and mentoring to staff providing Whole Health Pathway services. Oversees all Whole Health partners as well as the organization of <i>Introduction to Whole Health</i> sessions and the Pathway offerings.
<b>Whole Health partners</b>	Recruit Veterans to participate in Whole Health, facilitate <i>Introduction to Whole Health</i> and <i>TCMLH</i> group sessions and other programming within the Pathway, and provide ongoing support to Veterans.
<b>Volunteers/Veteran peer facilitators</b>	Can be utilized for the Pathway offerings, Well-being Programs, and CIH Services. Can hold many of the same roles and responsibilities as full-time employees (FTEs), but the recruitment/hiring process varies. Verify the recruitment process for each role to ensure proper onboarding of volunteers.
<b>Health and Wellness Coaches</b>  <b>Certified Health and Wellness Coaches</b>	Conduct individual or group coaching, in person, telephonically, or via telehealth. Recurring sessions are usually scheduled for several weeks up to several months depending on the arrangement of the Veteran and coach.  Certified Whole Health and Wellness Coaches have been certified by the National Board for Health & Wellness Coaching (NBHWC) and manage their own count clinics (either in-person or telehealth).  Note: If the coach is also a Veteran themselves, they may facilitate <i>Introduction to Whole Health</i> and <i>TCMLH</i> groups.
<b>Complementary and Integrative Health (CIH) providers</b>	Providers who treat illness, support health, and promote well-being using complementary and integrative health (CIH) approaches. Examples include, but are not limited to, yoga, meditation, and acupuncture.

Developing a plan for the transition of the key WHS roles to permanent, non-collateral positions should be undertaken with involvement of your local leadership. Whole Health partners, Whole Health coaches and volunteers will need to have an identified scope of practice, support in development of core competencies, and mentorship/supervision. The [Whole Health Human Resources SharePoint site](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WHHumanResources/Forms/AllItems.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WHHumanResources/Forms/AllItems.aspx>) is an ever-growing library of HR-related documents that can be referenced when developing competencies and/or scopes of practice. It is

recognized that, given their roles, Education Champions are likely to remain collateral positions. The Whole Health HR Modernization SharePoint site describes [criteria for selecting Facility Education Champions](https://dvagov.sharepoint.com/:w:/s/VHAOPCC/WH-Implementation/ESCxCq0PFedOI3W4Pgo2LcIBKpfd5oDY9Edk8ouqB5vIYg?e=VotBXX) (https://dvagov.sharepoint.com/:w:/s/VHAOPCC/WH-Implementation/ESCxCq0PFedOI3W4Pgo2LcIBKpfd5oDY9Edk8ouqB5vIYg?e=VotBXX).

Additionally, an environmental scan, resource evaluation, and needs and gap analysis will help to identify any CIH provider roles that will need to be hired or identified to support List 1 and any other CIH approaches to be offered. For further information about the provision of CIH services, visit the [CIH Policy section of the IHCC SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Policy.aspx) (https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Policy.aspx) including VHA Directive 1137 Provision of Complementary and Integrative Health (CIH).

### 5.2.2 Identifying Whole Health Staff

The best talent source for staffing Whole Health is likely within the site. It is recommended to connect with existing site leadership and staff to identify individuals interested in bringing their knowledge to bear in support of direct Whole Health implementation. A good starting point is engaging with staff who support existing VHA programs that are well-aligned with the Whole Health Model (e.g., Health Behavior Coordinators, Health Promotion Disease Prevention Program Managers, Registered Dietitian Nutritionists, Veterans Health Education Coordinators, and MOVE! Coordinators), as well as additional programs and their respective departments.

### 5.2.3 Embedding Whole Health into the Hiring Process

The National VA Credentialing Office suggests that each site develop its own local procedures and policies for vetting non-licensed, non-credentialed providers (e.g., yoga instructors, health coaches), as there is not currently a standardized hiring process for Whole Health employees. **To provide guidance, the OPCC&CT has developed position descriptions (PDs) or functional statements for many roles, including:**

- Tai Chi/Qigong instructor
- Yoga instructor
- Acupuncturist
- Whole Health coach
- Whole Health partner
- Whole Health clinical director
- Whole Health program manager
- Volunteer Whole Health group facilitator
- Whole Health program assistant

**PDs for these and other positions, including many facility-level examples, are available in the [Whole Health Positions SharePoint folder](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WHHumanResources/Forms/AllItems.aspx?viewid=81726be2%2D9a7a%2D41d3%2D9af2%2D6c06f7dc0d21&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FWHHumanResources%2FWH%5FPositions)** (https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WHHumanResources/Forms/AllItems.aspx?viewid=81726be2%2D9a7a%2D41d3%2D9af2%2D6c06f7dc0d21&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FWHHumanResources%2FWH%5FPositions).

To support the interview process for Whole Health-specific roles, and for further integration of Whole Health across the system, ensure that your site uses performance-based questions that ask for specific

cases and detailed examples of Whole Health-friendly interactions, including communication skills, empathic interactions, experience with Veterans, and a passion for caring for the health and well-being of others. Examples of performance-based questions from the [VA.gov PBI website](https://www.va.gov/pbi/) (<https://www.va.gov/pbi/>) can be useful as well.

The **use of the performance appraisal process to incentivize Whole Health activities is encouraged**. For example, dedicate a percentage of the performance appraisal to assess Whole Health education attended (self), spread (presented/shared with other staff) and seeded (Whole Health projects implemented/managed).

#### 5.2.4 Enlisting Volunteers to Support Whole Health

Effectively planning for and managing volunteers will be a necessary and ongoing part of any site's success with Whole Health implementation. In some cases, volunteers may be used prior to hiring dedicated Whole Health staff. Work with site leadership to determine the existing volunteer recruitment and training process, and explore the [Local Center for Development and Civic Engagement Directory website](https://www.volunteer.va.gov/directory/index.asp) (<https://www.volunteer.va.gov/directory/index.asp>) to identify your local Center for Development and Civic Engagement coordinator for assistance.

Trained volunteers are recommended as peer facilitators for the *Introduction to Whole Health* and *Taking Charge of My Life and Health (TCMLH)* courses. Examples of **Whole Health Volunteer Position Descriptions, including the Peer Facilitator Volunteer, and CIH Volunteer and WOC Employees** can be found in the [Whole Health Volunteer Positions SharePoint folder](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WHHumanResources/Forms/AllItems.aspx?id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FWHHumanResources%2FWH%5FPositions%2FVolunteer%5FPositions&viewid=81726be2%2D9a7a%2D41d3%2D9af2%2D6c06f7dc0d21) (<https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WHHumanResources/Forms/AllItems.aspx?id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FWHHumanResources%2FWH%5FPositions%2FVolunteer%5FPositions&viewid=81726be2%2D9a7a%2D41d3%2D9af2%2D6c06f7dc0d21>). **Many sites are also using volunteers for the provision of Whole Health-related services such as teaching well-being classes in yoga and Tai Chi.** Both national and facility examples of these position descriptions are included at the link above.

Just as with staff, it will be necessary to provide Whole Health volunteers with training appropriate to their assigned roles. Attendance at an *Introduction to Whole Health* class is recommended for all volunteers, regardless of their assigned duties, as a way to orient them to general Whole Health concepts in support of the facility's overall transformation efforts. More information regarding training requirements for peer facilitators can be found in section 6. Pathway Domain of this *Guide*.

For additional information regarding the use of volunteers, refer to section [10.5 Contributions by Volunteers](#) of this *Guide*.

#### 5.2.5 Credentialing Whole Health Providers

Providers of well-being approaches who come from the community (volunteers, FTE, or fee-basis) will not always be credentialed and privileged within the VA facility. The National VA Credentialing Office has given guidance on this and recommends that facilities develop their own local procedures and policies for vetting non-licensed, non-credentialed providers of health and well-being approaches. The OPCC&CT has developed position descriptions for minimum proficiencies for health coaching, yoga, and Tai Chi practitioners currently, and others may be added. Please note that this procedure does not apply to CIH treatment approaches such as acupuncture, massage therapy, and chiropractic, where it is



necessary to have licensed, credentialed, and privileged providers. For hiring these provider types, there are appropriate qualification standards and functional statements. **Position descriptions, functional statements, and qualification standards for Whole Health-related positions** can be found in the [Whole Health Positions SharePoint site](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WHHumanResources/Forms/AllItems.aspx?viewid=81726be2%2D9a7a%2D41d3%2D9af2%2D6c06f7dc0d21&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FWHHumanResources%2FWH%5FPositions) (https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WHHumanResources/Forms/AllItems.aspx?viewid=81726be2%2D9a7a%2D41d3%2D9af2%2D6c06f7dc0d21&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FWHHumanResources%2FWH%5FPositions).

### 5.2.6 Whole Health HR Modernization Resources

**OPCC&CT has partnered with Human Resources (HR) on the Whole Health/HR Modernization effort with a focus on developing Whole Health position descriptions for a variety of positions**, along with language for functional statements and other supporting/hiring documents. This document library is continually updated, and contains both nationally-developed and field-based examples. These resources can be accessed from the [Whole Health Human Resources SharePoint page](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WHHumanResources/Forms/AllItems.aspx) (https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WHHumanResources/Forms/AllItems.aspx).

### 5.3 Whole Health Training for Staff

Whole Health training and education is essential for staff, both in learning how Whole Health can be incorporated into their role as well as personally within their lives. When considering training options, work with your FIT Consultant to explore the most appropriate training options and venues.

Many sites are incorporating Whole Health into their New Employee Orientation (NEO). This provides an excellent opportunity to introduce new employees to the Whole Health model at the onset of their service in VA. Visit the Whole Health SharePoint for [examples of Whole Health NEO training](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Operations_Domain/Forms/AllItems.aspx?viewid=3d2aca78%2D56e1%2D4ed6%2D90c5%2D245dab505bf8&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FOperations%5FDomain%2FStaff%5FTraining%2FNEO) (https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Operations\_Domain/Forms/AllItems.aspx?viewid=3d2aca78%2D56e1%2D4ed6%2D90c5%2D245dab505bf8&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FOperations%5FDomain%2FStaff%5FTraining%2FNEO).

The OPCC&CT has developed several Whole Health trainings that are both in-person and online, as well as foundational and advanced options, examples of which are described in the table below. Many trainings are role-based; however, cross-functional training is beneficial, and staff should be encouraged to explore these trainings.

In instances where staff request more advanced training, sites should work with their FIT Consultant to explore options and available venues. To ensure optimization of skills developed in the advanced trainings, OPCC&CT will begin to offer a “classroom to practice course” that will encourage and enforce application of skills for implementation in the clinic setting, as well as an individual’s own expansion of self-care.

For online training programs, the Talent Management System (TMS) is utilized.



Table 3: OPCC&CT Whole Health Training Examples

In-Person Whole Health Training Courses*	Online and Advanced Whole Health Training*
Whole Health for Employees <ul style="list-style-type: none"> <li>• WH 102/102F</li> <li>• Train the Trainer</li> </ul>	Clinician Self-Care
Applying Whole Health in Clinical Care <ul style="list-style-type: none"> <li>• WH 202</li> <li>• Train the Trainer</li> </ul>	Introduction to Complementary and Integrative (CIH) Approaches  Mindful Awareness
Whole Health in Your Practice	Whole Health Foundation: A Personal Experience
Whole Health Clinical Care Symposium	Facilitation Tips and Techniques for Delivering <i>Taking Charge of My Life and Health</i>
Whole Health Coaching <ul style="list-style-type: none"> <li>• Foundations</li> <li>• VA Coaching Certificate</li> </ul>	Whole Health for Pain and Suffering Eating for Whole Health
Taking Charge of My Life and Health <ul style="list-style-type: none"> <li>• Facilitator Training</li> <li>• Train the Trainer</li> </ul>	Eating for Whole Health: Functional Approaches to Food and Drink  Whole Health for Mental Health
Whole Health Partner Skills Training	Personal Health Planning: Making It Real
Whole Health Mentor Course	Whole Health for All: Social and Structural Determinants of Health

\* **NOTE:** Whole Health trainings are subject to change. Refer to the [Whole Health Education SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Home.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Home.aspx>) for the current list of available trainings.

### 5.3.1 Additional Considerations for Staff Training

Local sites may also expand institutional knowledge by offering the following:

- **Whole Health Champions-** Identify individuals within various departments who understand and appreciate the Whole Health model to become Whole Health Champions within their respective departments. Whole Health Champions could be individuals who have attended the Whole Health Coaching and/or Whole Health Clinical courses, and/or who are members of a health promotion committee
- **Grand Rounds-** Connect with Service Chiefs or providers who manage educational affiliations and training programs. Offer to facilitate a Whole Health Grand Rounds in one or more services to inform medical providers, residents, and medical students working in those departments about Whole Health

- **Leadership Meetings**- Schedule a meeting with executive leadership at your site to describe the Whole Health System of care. Meet with Chiefs, department heads, and Administrative Officers of key departments to describe and emphasize the Whole Health System, and to encourage referrals. Likewise, consider meeting with key providers and leadership in various clinics (e.g., Primary Care, Pain Clinic, Pain Management & Rehabilitation) to review well-being services
- **Departmental Meetings**- Attend department staff meetings (e.g., Primary Care) to discuss Whole Health, and to present on the structure of the Well-being Program and how to refer
- Offer a point of contact at all meetings to enable attendees to provide feedback or ask questions after the meeting
- Incorporating the *Designation Framework* to augment training would be beneficial to both new and current staff by familiarizing them with the goals of the Whole Health System. This document can serve as a blueprint to guide staff to identify strengths and opportunities and focus attention on their specific needs. Refer to the [Designation Framework](https://dvagov.sharepoint.com/:w:/s/VHAOPCC/EUdWEp9OfqtGt3wL4-VZ3mIBIRzn6chrEYAyqfc7ffTdyw?e=2UkZpL) (<https://dvagov.sharepoint.com/:w:/s/VHAOPCC/EUdWEp9OfqtGt3wL4-VZ3mIBIRzn6chrEYAyqfc7ffTdyw?e=2UkZpL>)

Finally, staff training should also include the **principles of ADKAR** that are detailed in the [Smart Change Tool](#)

(<https://vaww.vashare.vha.va.gov/sites/NCOD/SitePages/SmartChange/SmartChangeToolsGuidance.aspx>) on the NCOD website. ADKAR has been adopted by the VA to address change management and the improvement of organizational outcomes. ADKAR is an acronym that represents the five tangible and concrete outcomes that are needed to achieve lasting change:

**A= Awareness**

**D= Desire**

**K= Knowledge**

**A= Ability**

**R= Reinforcement**

To provide effective Whole Health implementation that is both spread and sustained by facilities, ADKAR is a crucial and effective component.

### 5.3.2 VISN and National Support for Whole Health Education

In order to maximize accessibility to Whole Health education, OPCC&CT is gradually transitioning to a greater emphasis on local courses and VISN coordination of Whole Health training. This transition started with the creation of Network-Wide Education Coordinator (NWECC) positions in FY20 (2 per VISN) that are partially funded by OPCC&CT. NWECCs are responsible for creating their VISN's strategic plan for Whole Health training. Beginning in FY22, OPCC&CT will expand its support by creating and funding Network-Wide Education Faculty (NWEF) positions, with an eventual goal of supporting a total of five faculty in every VISN. These faculty will teach and develop Whole Health courses at the VISN level.

FIT will collaborate with local staff including Flagship Education Champions (FEC), NWECCs, NWEFs, and Local Education Coordinators (LoEC) to expand local offerings to eventually include the national

synchronous courses and a range of short courses designed for specific audiences, including executive and service line leadership, nursing, mental health staff, and others identified as priorities by the field.

**The various Whole Health education roles are summarized in the following table:**

*Table 4: Education Roles and Acronyms*

<b>Role</b>	<b>Responsibilities</b>
<b>National Education Champion (NEC)</b>	Skilled faculty and facilitators who teach National Whole Health courses (Whole Health in Your Practice, Whole Health for Mental Health, Whole Health for Pain & Suffering, etc.). NECs have .2 or more of their FTE reimbursed by OPCC&CT for this work.
<b>Flagship Education Champion (FEC)</b>	Skilled faculty and facilitators who teach and develop local level courses (Whole Health 102 & 202, etc.) at Flagship Sites. FECs have been supported locally thru Flagship monies, but for the entirety of FY21 will have 2 faculty at each flagship at .2 FTE supported directly by OPCC&CT.
<b>Network-wide Education Coordinator (NWECC)</b>	Skilled strategists who assist the Networks in developing a network-wide strategic plan for Whole Health Education. There are 2 NWECCs in each Network supported at .2 FTE by OPCC&CT.
<b>Network-wide Education Faculty (NWEF)</b>	Skilled faculty and facilitators who will teach and develop courses at the network level. Initially there will be 2 NWEFs at .2 FTE supported by OPCC&CT with plans to increase to a total of 5 faculty in each network over several years. *This is a new role that will begin in FY22
<b>Local Education Champion (LoEC)</b>	Any skilled faculty or facilitator who is teaching local Whole Health courses but may not be located at a Flagship facility. OPCC&CT will provide orientation and resources to these faculty as interested.

## 5.4 Service Line to Support Whole Health

The Whole Health System and the term 'Whole Health' includes the entirety of the healthcare system (i.e., every encounter the VA makes with the Veteran).

**Whole Health should not be isolated to one specific service line, but instead is the transformation of care in every service line within a VA facility.**

It is recognized that the Whole Health System *does* have programmatic components, including Pathway programming and Well-being programming. These are often staffed by many CIH and well-being roles, as well as by volunteers and Veterans (e.g., Whole Health partners/peers, health coaches, well-being class facilitators, and CIH providers). Additionally, the transformation of an entire organization into the Whole Health culture requires concerted effort from leaders and administrative staff dedicated to support the Whole Health transformation. When hiring Whole Health leaders (e.g., Whole Health clinical director, Whole Health program manager, etc.), Whole Health administrative staff, and CIH and well-

being providers, it is up to the facility to decide the appropriate organizational structure for these new staff members. Options for consideration include:

- **Option 1: Utilize Established Service Line(s):** Whole Health leaders, Whole Health administrative staff, Pathway staff and Well-being Program staff could be housed within an established service line (e.g., PACT, PM&R), especially if the service line leadership is supportive and willing to share resources. Whole Health leaders would not only supervise Pathway and Well-being Program staff, but also lead the Whole Health transformation across the organization. Additionally, Pathway and Well-being staff could provide CIH and well-being approaches within these programs, and could be deployed across the organization to provide these approaches in other service lines as well.
- **Option 2: Create a New Service Line:** Whole Health leaders, Whole Health administrative staff, Pathway staff, and Well-being program staff could be housed within a new service line. Possible service line names include: CIH & Well-being, Well-being, or Whole Health Operations. Regardless of the name, it is essential that the intention of this service line is not only to house the programmatic pieces of the Whole Health System (i.e., Pathway and Well-being Program and staff) but also to support the rest of the organization in its Whole Health transformation. Thus, Whole Health leaders would not only supervise Pathway and Well-being Program staff, but also lead the Whole Health transformation across the organization. Additionally, Pathway and Well-being Program staff could provide CIH and well-being approaches within these programs and could be deployed across the organization to provide these approaches in other service lines as well.

The following considerations may be helpful in deciding which option is best for your facility:

1. It is not mandatory to have a new service line to fully implement the Whole Health System.
2. Whole Health leaders, Whole Health administrative staff, Pathway staff and Well-being Program staff could be initially housed within an established service line, and then move into a new service line when the site determines the need for extra infrastructure and administrative oversight for Whole Health staff.
3. A new service line to support Whole Health transformation provides administrative oversight and mentorship to Whole Health staff.
4. As described above, ideally, if creating a new service line to support Whole Health transformation, staff would not only provide care within that service line but also be deployed across the enterprise to support Whole Health activities in other service lines (similar to Nursing Services and OI&T).
  - For example, a yoga instructor from the new service line could provide a yoga class within the pain clinic, versus the pain clinic hiring a yoga instructor within their service line to provide this class.
  - There is a cost benefit to implementing CIH and well-being services this way. The cost per encounter decreases in this scenario because these services do not assume the more expensive overhead costs of other service lines. For example, healing touch within palliative care can have a high cost per encounter because of the overhead cost associated with palliative care. However, if a well-being provider was to be deployed from the new service

line to provide healing touch in this instance, a different overhead cost would be associated with the encounter and the cost per encounter would decrease.

## 5.5 Space Planning

**Space will likely be needed for a range of new activities associated with Whole Health implementation** (e.g., new hire workstations, Veteran coaching, group classrooms, well-being activities, and CIH treatment rooms). Additionally, the Whole Health approach emphasizes the provision of a healing environment in which to work and to provide care. As such, initiating actions/requests to secure space either on campus or offsite for initial Whole Health System components and staff will be needed.

**An initial first step in space planning is to conduct a needs assessment and gap analysis** that includes both an internal and external (community) environmental scan. This analysis can then be used to develop an initial Whole Health space plan, which can be done with the support of your FIT Consultant. Incorporating stakeholder feedback to include Veterans, family, and caregivers throughout the planning process is recommended. It is also recommended that the Whole Health team reach out early in the process to the facility space planners and engineers, including the Chief Engineer. A strong working relationship and partnership with these groups will support development of realistic and adequate planning and goals. Acquisition or construction of new space, relocation, and renovation of existing space can be a complex process with many prerequisites and restrictions. Involving facility space planners and Engineering early can aid with problem solving and design. Bringing them on as members of your Whole Health team early in the process will help them to understand the goals of Whole Health as well as what you need and why.

As your site's Whole Health journey begins, it may be necessary to "borrow" space at first, such as a large room within the facility in which to conduct Whole Health trainings or to offer a Well-being Program. As Whole Health grows and expands, the need to acquire dedicated space will arise or, optionally, you may choose to integrate into existing areas. Physically integrating Whole Health throughout the facility and into existing areas has the added benefit of weaving Whole Health into the everyday fabric of how we deliver care to our Veterans. Additionally, space may be identified offsite to support Whole Health, such as for Pathway and well-being offerings.

Regardless of the type of space (temporary, borrowed, or permanent), the goal should be to make the space into a healing environment that reduces stressors and aids in recovery. Ultimately, assuring that sufficient space is available to conduct Whole Health work either onsite or through offsite agreements will be needed. While the extent of your site's ability to fully create a healing environment will vary. At a minimum the following characteristics should be included:

- Warm, welcoming, and comfortable
- Easily navigated and convenient to access
- Supportive of both Veteran and employee use
- Accessible to daylight and nature with warm, adjustable lighting
- Provide appropriate sound levels with adequate privacy

When longer-term planning involves requesting more space from the facility, the estimated space requirements can be calculated from the [Whole Health Cost Matrix worksheet](https://dvagov.sharepoint.com/:x:/s/VHAOPCC/WH-Implementation/ES-) (<https://dvagov.sharepoint.com/:x:/s/VHAOPCC/WH-Implementation/ES->

fr\_Ohsnplj1BAUKqKoz0BuUpdpl435oXLQxk1QyFJkA?e=e7B3g0). This worksheet can be utilized as an aid to support the business case for requesting space. Note that not all Whole Health offerings must be available onsite. Seeking community partnerships and exploring telehealth are excellent options to expand available space.

### 5.5.1 Creating Healing Environments

As part of Whole Health System implementation, the site should appoint, as a collateral duty, a Healing Environments champion who will represent the need for the required space in planning and implementation. This process would include a needs assessment to determine how much and what kind of space is needed, if the space should be on or off-site, as well as the organization of an Integrated Project Team (IPT) consisting of Veteran and staff stakeholders to provide input into planning and design. **Additional guidance for creating healing environments** can be found in the [collection of OPCC&CT toolkits and project overviews on SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/Innovations/ToolkitsProjectOverviews/Forms/AllItems.aspx?viewid=94be29e6%2D14ac%2D4442%2Db341%2D74b659991369&id=%2Fsites%2FVHAOPCC%2Finnovations%2FToolkitsProjectOverviews)

(<https://dvagov.sharepoint.com/sites/VHAOPCC/Innovations/ToolkitsProjectOverviews/Forms/AllItems.aspx?viewid=94be29e6%2D14ac%2D4442%2Db341%2D74b659991369&id=%2Fsites%2FVHAOPCC%2Finnovations%2FToolkitsProjectOverviews>).

## 5.6 Communications and Advertising

The idea of Whole Health may still be new to some; therefore, it is important to communicate the benefits of this approach to health and well-being, as well as to encourage engagement. Effective strategies, outlets, and tools for communication and outreach will be needed for a wide variety of stakeholders.

To achieve this, an initial and ongoing Whole Health communications strategy should be developed at the site level. The communications strategy should articulate goals, necessary resources, measures of success, and planned activities. An inventory of existing site communications and messaging should be created to identify baseline Whole Health awareness and to inform the communications strategy. The communications strategy and associated plan should also include approaches that address both internal (e.g., clinical and ancillary site staff) and external (e.g., community partners) VHA stakeholders and provide intentional and consistent messaging in support of a common set of Whole Health-oriented goals. Refer to **examples of facility-level Whole Health communications plans and template in the Operations Domain SharePoint folder** ([https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Operations\\_Domain/Forms/AllItems.aspx?viewid=3d2aca78%2D56e1%2D4ed6%2D90c5%2D245dab505bf8&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FOperations%5FDomain%2FCommunication%5FPlans](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Operations_Domain/Forms/AllItems.aspx?viewid=3d2aca78%2D56e1%2D4ed6%2D90c5%2D245dab505bf8&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FOperations%5FDomain%2FCommunication%5FPlans)).

Key aims of the communications strategy include raising staff awareness of the status of the site's Whole Health implementation goals and actions, increasing Whole Health practice adoption, and increasing Veteran interest in, and uptake of, Whole Health services. Internal partners, communications experts, and the Public Relations Office should be engaged in this communications effort. Once the strategy is defined, it is important to translate the strategic thinking into a communications action plan and timetable. In the action plan, specific communications vehicles can be noted with steps required to secure site-specific materials such as formal welcome letters, introductory kick-off sessions, monthly newsletters, awareness campaigns, social media, web blogs, fairs, email blasts, town hall meetings, staff

meetings, New Veteran Orientation, New Employee Orientation, and participation in community activities.

The following actions should be considered as the communications strategy and plan is developed:

- Identification of main audiences
- Development of primary Whole Health messages
- Identification of site resources and local communications experts who can partner with the Whole Health team to facilitate Whole Health messaging
- Exploration of communications vehicles that can be leveraged (e.g., check-in desks)
- Review of successful past or current program campaigns to understand what works best
- Assessment of the baseline level of awareness of Whole Health opportunities
- Development of a plan of activities and a timetable

**To support your site's Communication efforts, OPCC&CT provides a wide variety of communication resources on the [Communication Resources SharePoint site](https://dvagov.sharepoint.com/sites/VHAOPCC/sitepages/communication-resources.aspx)**

(<https://dvagov.sharepoint.com/sites/VHAOPCC/sitepages/communication-resources.aspx>). These include

- Whole Health logos and graphics
- Whole Health branded products (posters, flyers, brochures, etc.)
- Whole Health Outreach Toolkit
- Whole Health templates (PowerPoint presentations, etc.)
- Print products available from the VA Depot
- Downloadable files for PHI, PHP, etc.
- Whole Health System photo vault where you can find or share images
- Whole Health videos
- Links to #LiveWholeHealth blog, VA Whole Health internet, etc.
- Monthly Whole Health Communications Plans

Sites are strongly encouraged to utilize these resources as they will greatly simplify a site's communication efforts. In particular, they contain already-crafted language for posting about Whole Health on a variety of social media and internet platforms.

#### 5.6.1 Advertising Whole Health

Advertising Whole Health, both internally and externally, is an important part of sharing the message. Successful methods include using commercials, posters, or flyers, as well as taking opportunities to participate in meetings, events, and programs to impart knowledge about Whole Health. It is essential to work collaboratively with your Public Affairs Officer to determine the best way to share Whole Health messaging outside of the VA (e.g., Town Halls and Welcome Home/Stand Down events) and, especially if not using official OPCC&CT products, to vet any locally-developed materials (e.g., program flyers, brochures, and social media) for proper language, style, and formatting before distribution. Be sure to **leverage the wide variety of communication resources on the [Communication Resources SharePoint site](https://dvagov.sharepoint.com/sites/VHAOPCC/sitepages/communication-resources.aspx)** (<https://dvagov.sharepoint.com/sites/VHAOPCC/sitepages/communication-resources.aspx>) prior to developing materials locally.



General approaches to advertising Whole Health may include the following (and be sure to work with your local Public Affairs Officer to do so):

- Hanging large informational posters around the facility
- Post on Facebook, Twitter, and/or your facility's local website
- Advertise *TCMLH* groups on digital signage boards
- Plan a "Whole Health Day" event for staff to learn about and experience Whole Health
- Secure a table in the atrium to advertise the program with brochures, informational handouts, and a large poster board. Be ready to answer questions and take direct referrals from Veterans
- Partner with the department that manages staff onboarding at your facility and inquire if you can briefly present the Whole Health model
- Partner with the Business Office and eligibility staff to promote Whole Health to newly-enrolling Veterans

For further suggestions for advertising and recruiting Veterans for Whole Health Pathway services, refer to section 6. [Pathway Domain](#) of this *Guide*.

## 5.7 Setting up Whole Health Documentation and Workload Tracking Tools

Whole Health is a significant priority for the VHA. Therefore, the work of Whole Health is being documented and tracked through the Computerized Patient Record System (CPRS)-based national tracking mechanisms to understand and evaluate both the utilization and cost of Whole Health.

**Collaboration between Whole Health clinicians, program managers, local Managerial and Cost Accounting Office (MCAO) representatives, Automated Data Processing Application Coordinators (ADPACs), and Clinical Application Coordinators (CACs) is critical to ensure the work of Whole Health is being appropriately recorded.** A critical first step is to complete an environmental scan or inventory of all Whole Health services offered, including CIH, to ensure all Whole Health workload is captured. This environmental scan and needs/gap analysis should be repeated intermittently to ensure that Whole Health offerings are sufficient to meet demand, either internally or through community partnerships.

There are a **variety of tracking mechanisms that can be used to document the provision of Whole Health services**, such as clinic profile stop codes, four-character (CHAR4) codes, procedure codes, health factors, and note titles. Each of these mechanisms have their own applications in the tracking of Whole Health. Some involve changing the profile of an entire clinic; others can be used on an "as needed" basis by a clinician depending on the unique nature of every encounter. By using the available tracking mechanisms, facilities will be able to ensure that all Whole Health approaches (including those offered in the Pathway, Well-being Programs, and Whole Health Clinical Care) are accounted for in the local and national tracking of utilization. Processes for routine review of coding and tracking accuracy should be in place to ensure accurate capture of local Whole Health offerings. Once your tracking processes are established, encourage adherence among staff and actively review site-based data to determine compliance.

The [Whole Health System Tracking Guidance SharePoint](#)

(<https://dvagov.sharepoint.com/sites/VHAOPCC/SitePages/Whole-Health-System-Coding-Guidance.aspx>) provides in-depth information on all national tracking mechanisms. It provides a general overview of tracking mechanisms that are used at the VHA, as well as recommendations as to how facilities can use these mechanisms to document work within the Whole Health System.



Additionally, a [Whole Health Dashboard](https://dvagov.sharepoint.com/sites/VHAOPCC/sitePages/Whole-health-dashboards.aspx)

(<https://dvagov.sharepoint.com/sites/VHAOPCC/sitePages/Whole-health-dashboards.aspx>) has been developed to assist sites in reviewing the amount and type of Whole Health workload that is being recorded by VSSC and MCAO for each VA facility and their CBOCs, as well as other sites of care. Site-based Whole Health implementation teams can review data to assist in self-monitoring.

Another resource is the OPCC&CT Whole Health Coding and Tracking Team, which is available to answer coding or clinic set-up questions by [emailing the Whole Health Coding and Tracking Team](mailto:VHAOPCC&CTWHSTrackingTeam@va.gov) (VHAOPCC&CTWHSTrackingTeam@va.gov).

Finally, it should be noted that **VHA is currently in the process of transitioning from the CPRS to a new patient care documentation system developed by the Cerner Corporation.** The transition to the Cerner System will take place gradually over 10 years and is rolling out slowly in select VISNs. The Cerner system will differ from CPRS/VISTA in that it will not require clinic set up (Stop Codes, CHAR4 Codes, and Health Factors) to capture Whole Health work. The tracking mechanisms for Whole Health will instead be captured through the documentation process and through placing Charge Orders. As your VISN and facility begins its transition to the Cerner System, you will receive education and training from Cerner. You will also receive guidance from your FIT Consultant on the specifics of the documentation process to ensure that you capture your Whole Health work accurately. For the most up-to-date information, refer to the Cerner resources posted on the [Whole Health System Tracking Guidance SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/SitePages/Whole-Health-System-Coding-Guidance.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/SitePages/Whole-Health-System-Coding-Guidance.aspx>).

#### 5.7.1 Whole Health Notes and Referrals

Within the Whole Health System, there are clinical and non-clinical referral types and associated processes that need to be established before you can begin offering certain Whole Health activities. Whole Health Clinical Care referrals and their corresponding consults follow the standard process for clinical visits. However, for non-clinical referrals, which are those referrals generated through activities under the Pathway and Well-being Programs, there is a set of actions to take based on the Veteran encounter. For Veterans interested in engaging with Pathway and Well-being Programs elements that are non-clinical (e.g., yoga, Tai Chi), an educational consult is required. It is important to confirm this guidance with your site's practice of care standards and/or your VISN guidelines to confirm which site roles can enter consults for Whole Health. Note that guidance will be provided on how this process may shift when your VISN transitions from CPRS/VISTA to Cerner at that time.

It is important to consider the Veteran's readiness to participate in Whole Health when deciding to refer to Whole Health services. Some Whole Health programs require time, energy, and a level of engagement that not everyone can commit to. Although enrollment and "trying it out" are encouraged, it may not be helpful to excessively refer Veterans who appear unsure about Whole Health offerings or their ability to participate. As an organization, we want to encourage positive initial experiences with Whole Health among Veterans and guard against sub-optimal class or program sizes due to Veteran "no-shows." Many Whole Health programs work best when everyone shows up to participate.

Guidance for Whole Health provided through Community Care, including around Standardized Consult Template Guidance, can be found on the Community Care section of the [IHCC SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/About.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/About.aspx>).

Finally, examples of both national and local-level CPRS documentation and consult templates are available in the [WHS Coding and Tracking Guidance SharePoint folder](https://dvagov.sharepoint.com/sites/VHAOPCC/Shared%20Documents/Forms/AllItems.aspx?RootFolder=%2Fsites%2FVHAOPCC%2FShared%20Documents%2FCIH%20Coding%20Guidance%2FNote%20Title%20Templates&FolderCTID=0x012000965D235B81AE9A40B070A146F202ECC1) (https://dvagov.sharepoint.com/sites/VHAOPCC/Shared%20Documents/Forms/AllItems.aspx?RootFolder=%2Fsites%2FVHAOPCC%2FShared%20Documents%2FCIH%20Coding%20Guidance%2FNote%20Title%20Templates&FolderCTID=0x012000965D235B81AE9A40B070A146F202ECC1).

### 5.7.2 Establishing Non-Clinical Referral Processes

**It is valuable to establish a non-clinical referral process at your site.** To do this, you may start by generating content for the CPRS consult for any non-clinical, Whole Health-related programs your site or your Whole Health partners are offering. An additional source of support can come from working with Medical Informatics at your facility and/or your ADPAC to create a consult referral, the title of which must start with the word “Consult.” As you develop your process and utilize various tools, it will help if the templates you create have the exact wording and response fields needed for your Whole Health efforts. Please note, you will also need to create a “Consult Note” to use when closing your consult. Work with your CAC and/or ADPAC to create a “Consult Note” so that the consult can be completed. If the consult is directed to group sessions, a “Consult Note” can also be set up as a group note, which can make completion easier.

For site roles that require entering a referral for a patient to Whole Health, the first step is to create a CPRS consult as a referral. The referral through CPRS provides a way to track utilization of Whole Health services, which supports broader reporting and reimbursement systems. When the Consult Note is generated, it should contain information as to why the referral is being requested. The consult referral is also a way to obtain medical clearance when needed (i.e., the Veteran’s medical provider can be alerted to the consult to review and sign off, without requiring Veteran contact).

**Remember that VHA policy governs aspects of consults, such as timeframes for initial contact to be made and for completion to occur. Completion or “closing” the consult can be done by writing a consult for attendance. The number of Whole Health sessions needed weekly will be determined by the volume of referrals to the program. Although a Veteran may be referred for a specific service, it is essential that the Veteran can develop and design their own plan for engaging with the Whole Health program.**

As noted previously, when your VISN begins its transition to the Cerner system, additional guidance will be provided by both Cerner and your FIT Consultant as to how this process may differ in the new platform.

### 5.7.3 CPRS Access for Whole Health Providers

Ideally, non-clinical well-being and CIH providers, such as Whole Health coaches, Whole Health partners, yoga instructors, etc. will have access to CPRS. These providers can then document notes in CPRS.

If the CIH or well-being provider does not have CPRS access, and access is not planned for that provider, another VHA provider should administratively enter a note in a “non-count” clinic. Consult your site’s Whole Health leadership to determine the appropriate VA provider for this action.

In cases where a new provider will receive CPRS access, the following steps are required, and can be supported by your Administrative Officer or ADPAC:

- Provider background check
- Entry of the provider into the VA system
- Provider completion of TMS trainings (Health Insurance Portability and Accountability Act (HIPAA), Information Security, etc.)

Note: Ensure the new provider is entered in the Human Resources (HR) record under “Labor Mapping Application” with the correct taxonomy for “person class” and “user class” as listed in the [Whole Health Person Class Taxonomies guidance](https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/WH-Implementation/Operations_Domain/Coding/Relevant_WH_Person_Class_Taxonomies.docx?d=wb7dc3064db540ed86f68a35d790200a&csf=1&web=1&e=kMC2Zs) (https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/WH-Implementation/Operations\_Domain/Coding/Relevant\_WH\_Person\_Class\_Taxonomies.docx?d=wb7dc3064db540ed86f68a35d790200a&csf=1&web=1&e=kMC2Zs). Some user classes require a co-signer. Human Resources and Medical Informatics can help you choose the right classes.

Note that, within the Cerner system, all Whole Health roles to include Whole Health partners, Whole Health coaches, CIH providers, and volunteers will have roles available. Further guidance will be provided as your VISN begins its transition to the Cerner platform.

#### 5.7.4 Special Considerations for Documentation of Personal Health Planning

**Personal health planning and the availability of a Personal Health Plan (PHP) for both Veterans and their Whole Health Team is an operational integrator that requires methods for documentation and tracking across all components of the Whole Health System.** The remainder of this section discusses the key items to consider when supporting personal health planning.

Central to personal health planning is recognition and understanding of the patient’s Mission, Aspiration, and Purpose (MAP) which is typically derived from the Personal Health Inventory (PHI). **It is important for the Veteran to have ongoing access to their PHI and MAP to update their progress or to make desired changes to their plan.** Initiation of a PHI can occur in many settings throughout the Whole Health System. Some examples include:

- In the Pathway with Whole Health partners in individual and/or group settings
- In *Taking Charge of My Life and Health* facilitated groups
- In Whole Health coaching sessions (individual and/or group in Well-being or Whole Health Clinical Care settings)

The PHI can be further developed and documented in a Veteran’s Personal Health Plan to identify shared goals. Education about Whole Health and personal health planning should be made readily available to both Veterans and staff to ensure adoption of the PHP across stakeholders. It is important that personal health planning, including the Veteran’s MAP, be incorporated into all components of the Whole Health System. This will require communication by key leaders across disciplines.

The national PHP template is available for download to assist sites in developing a documentation and communication plan that is as seamless, simple, and effective as possible. Refer to the [PHP template and FAQs](https://vaww.va.gov/PATIENTCENTEREDCARE/FAQ_Personal-Health-Plan-Template.asp) (https://vaww.va.gov/PATIENTCENTEREDCARE/FAQ\_Personal-Health-Plan-Template.asp).

Sites are encouraged to download and use the national PHP template instead of developing other local methods or templates. Once downloaded, the PHP template will appear on the Postings Tab in CPRS for

all providers and caregivers to access. Instructions on how to download and implement the PHP can be found in the [WHS Coding and Tracking Guidance](https://dvagov.sharepoint.com/sites/VHAOPCC/Shared%20Documents/Forms/AllItems.aspx?RootFolder=/sites/VHAOPCC/Shared%20Documents/CIH%20Coding%20Guidance&FolderCTID=0x01200092D5EAC253479641B8D0A20FE4165E94) (https://dvagov.sharepoint.com/sites/VHAOPCC/Shared%20Documents/Forms/AllItems.aspx?RootFolder=/sites/VHAOPCC/Shared%20Documents/CIH%20Coding%20Guidance&FolderCTID=0x01200092D5EAC253479641B8D0A20FE4165E94). The tracking guidance also provides instructions on how to download and implement the Integrative Health Note Title and Whole Health Encounter templates which can assist in both coding and tracking of Whole Health and CIH activities. It is important to use these templates to allow providers and Veterans to have a consistent picture and shared understanding. Several Whole Health roles including Whole Health partners, Whole Health coaches, volunteers, and providers are able to enter relevant information into the PHP.

A national [PHI template and FAQs](https://dvagov.sharepoint.com/sites/VHAOPCC/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x012000965D235B81AE9A40B070A146F202ECC1&viewid=4ba2c7d3%2Dd49a%2D456c%2Da49a%2Db6b2153c997b&id=%2Fsites%2FVHAOPCC%2FShared%20Documents%2FCIH%20Coding%20Guidance%2FNote%20Title%20Templates%2FNational%20Note%20Templates)

(https://dvagov.sharepoint.com/sites/VHAOPCC/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x012000965D235B81AE9A40B070A146F202ECC1&viewid=4ba2c7d3%2Dd49a%2D456c%2Da49a%2Db6b2153c997b&id=%2Fsites%2FVHAOPCC%2FShared%20Documents%2FCIH%20Coding%20Guidance%2FNote%20Title%20Templates%2FNational%20Note%20Templates) is also available.

## 5.8 Supporting Veteran Travel Needs

In the Whole Health model, Veterans may enroll in well-being programs or receive CIH services that require travel, or more frequent travel to the site than prior models of care required. In some situations, the Veteran may require financial support or other accommodation (e.g., accessibility) to come to the site to participate in these activities. Your site should have a process in place to support these needs (e.g., travel pay and transportation support). Facility requirements and regulations regarding transportation to and from the VAMC may vary, so sites are advised to partner with their local travel department. Typically, Veterans who qualify for travel reimbursement may obtain two-way travel pay for scheduled appointments and one-way travel pay for drop-in appointments.

Official guidance from Veterans Affairs Central Office Beneficiary Travel states that well-being programs and CIH services offered in non-count clinics *can* use travel pay, since travel pay is based on Veteran eligibility and the medical benefits package. Due to VHA Directive 1137: Provision of Complementary and Integrative Health, well-being services in non-count clinics are included in the medical benefits package and are therefore eligible for travel pay.

### Resources:

[Operations Domain SharePoint Document Library](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Operations_Domain/Forms/AllItems.aspx) (https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Operations\_Domain/Forms/AllItems.aspx)

[Whole Health Human Resources SharePoint Document Library](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WHHumanResources/Forms/AllItems.aspx)  
(https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WHHumanResources/Forms/AllItems.aspx)

[Communication Resources SharePoint site](https://dvagov.sharepoint.com/sites/VHAOPCC/sitepages/communication-resources.aspx)  
(https://dvagov.sharepoint.com/sites/VHAOPCC/sitepages/communication-resources.aspx)

[Whole Health System Tracking Guidance SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/SitePages/Whole-Health-System-Coding-Guidance.aspx)

(<https://dvagov.sharepoint.com/sites/VHAOPCC/SitePages/Whole-Health-System-Coding-Guidance.aspx>)

[Whole Health Dashboard](https://dvagov.sharepoint.com/sites/VHAOPCC/sitePages/Whole-health-dashboards.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/sitePages/Whole-health-dashboards.aspx>)

[Other Operations-Related Toolkits/Project Overviews](https://dvagov.sharepoint.com/sites/VHAOPCC/Innovations/ToolkitsProjectOverviews/Forms/AllItems.aspx?viewid=94be29e6%2D14ac%2D4442%2Db341%2D74b659991369&id=%2Fsites%2FVHAOPCC%2Finnovations%2FToolkitsProjectOverviews)

(<https://dvagov.sharepoint.com/sites/VHAOPCC/Innovations/ToolkitsProjectOverviews/Forms/AllItems.aspx?viewid=94be29e6%2D14ac%2D4442%2Db341%2D74b659991369&id=%2Fsites%2FVHAOPCC%2Finnovations%2FToolkitsProjectOverviews>). This is collection of previous OPCC&CT innovations grant summaries, including programming ideas that are related to Whole Health operations, such as:

- Interactive Patient Care (IPC) technology
- Guidance on clinical reminders
- Healing environments toolkits
- And more

## 6. Pathway Domain

### 6.1 What is the Pathway

**The Pathway component of the Whole Health System (WHS) empowers Veterans to discover what really matters to them through mindful self-exploration of their mission, aspiration and purpose (MAP), and to set personal goals that allow them to be actively engaged in optimizing their health and well-being. The Pathway is not a specific physical location, but rather a set of various Whole Health (WH) programs and supportive services provided by trained and qualified individuals, preferably by fellow Veteran peers, that are designed to help Veterans begin and maintain their journey to well-being.**

In contrast to more traditional health care which is often a passive experience where care is done *to* an individual, Whole Health, especially **the Pathway, seeks to empower and partner with Veterans** to fully engage in their personal journey to Well-being. Veterans may be paired with Pathway team members (peers, facilitators, Whole Health partners, Peer Support Specialists, and volunteer Whole Health peer facilitators for non-clinical individual sessions and/or may attend non-clinical group sessions. Key aspects of Pathway services include cultivating mindful awareness practices in Veterans so that they may intentionally engage in self-exploration of what they want their health for, as well as utilizing tools such as the Personal Health Inventory (PHI) and the Circle of Health to assist in identifying areas of focus. Individuals desiring to make changes will be supported in the setting of SMART goals and action steps, while also exploring possible barriers. Veterans are able to document their goals and MAP in a Personal Health Plan (PHP), and may utilize this tool to serve as a foundation for shared decision making for health and well-being. To maintain progress, Veterans receive ongoing support on their well-being journey from fellow groups members and their local Pathway team.

### 6.2 Key Components of the Pathway

**The *Introduction to Whole Health* and *Taking Charge of My Life and Health (TCMLH)* are the two main Whole Health groups offered in the Pathway.**

The *Introduction to Whole Health* is a 2-hour educational and experiential session based on a specific curriculum that exposes participants to the foundational concepts of Whole Health and allows time for self-care and self-exploration through completion of a PHI. Facilitators of *Introduction to Whole Health* (e.g. Whole Health partners, Veteran peers, volunteers, Peer Support Specialists, and Whole Health coaches) receive a 2-hour virtual training to learn how to deliver these sessions. Online training for *Introduction to Whole Health* peer facilitators is available in the Talent Management System (TMS) course #35647. Curriculum, materials and guidance for these sessions are available on [OPCC&CT's Executive Order SharePoint page](https://dvagov.sharepoint.com/sites/VHAOPCC/2018ExecutiveOrderGuidanceTraining/Forms/AllItems.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/2018ExecutiveOrderGuidanceTraining/Forms/AllItems.aspx>).

*TCMLH* is a longer-term facilitated group program based on a specific curriculum. A series of topics centered around the eight elements of the Circle of Health assist Veterans in taking a deeper look into their lives to identify the specific areas they may wish to enhance. Veterans are then encouraged to create SMART goals with action steps that will help them attain these goals. Specifically, *TCMLH* participants:

- Examine the Circle of Health and set SMART goals drawn from that exploration
- Identify actions necessary to pursue their MAP and/or to act upon the referrals or additional resources needed to support shared and SMART goals. Resources and/or referrals may include Whole Health coaching with a Whole Health coach, referrals to self-care or skill building programs, including CIH, or referrals to Integrated Health and clinical care
- Develop a basic Personal Health Plan (PHP) to summarize the process of MAP exploration and the development of goals and action steps

*TCMLH* is a non-clinical group offering that can be structured in a variety of formats to meet the needs of Veterans and match each facility's resources. The original format is a 9-week program consisting of a 90-minute group session once each week. However, the curriculum may be consolidated to be offered in a shorter timeframe, such as over a 6-week period or as a weekend retreat. Such variations are discussed during *TCMLH Facilitator* training and in the facilitator manual. *TCMLH* can also be offered in community settings such as at colleges, YMCAs, Veterans Service Organizations (VSO), Vet Centers, etc. Finally, sites can explore virtual platforms, such as VA Video Connect, when offering the sessions to reach as many Veterans as possible.

*TCMLH* facilitators (e.g. Veteran peers, Whole Health partners, volunteers, Peer Support Specialists) receive a 3-day, in-person training to learn how to deliver the *TCMLH* group program. A train-the-trainer format has also been developed to allow sites to send individuals to learn how to conduct on-demand *TCMLH* facilitator training at the local/VISN level. Details can be found on the [OPCC&CT Education Facilitated Groups SharePoint page](https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Whole-Health-Facilitated-Groups.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Whole-Health-Facilitated-Groups.aspx>).

#### 6.2.1 Introduction to Whole Health and *TCMLH* Planning and Set Up

Based on the space and other resources available at your site, assess how many Veterans will be needed to start a group. For example, if you are seeking 15 Veterans to begin a group, consider what efforts will be needed, in terms of outreach and communications, to achieve that number? To account for program attrition over time (i.e., Veterans dropping out), sign up twice the number of Veterans to ensure an optimal session size. For example, you may want to sign up 30 Veterans to end up with a final group of 15 Veterans. Remember, too, that Veterans may bring family members, so plan space needs accordingly.

Ensure that clinics have been properly set up and coded, and that processes for workload capture and referrals are firmly in place. Refer to section 5.7 Setting up Whole Health Documentation and Workload Tracking Tools of this guide and the [WHS Coding and Tracking Guidance SharePoint page](https://dvagov.sharepoint.com/sites/VHAOPCC/SitePages/Whole-Health-System-Coding-Guidance.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/SitePages/Whole-Health-System-Coding-Guidance.aspx>) for further information about these important topics.

Finally, facilitating *TCMLH* will require materials and resources as listed in the facilitator guide. Consult the [TCMLH curriculum](https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Whole-Health-Facilitated-Groups.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Whole-Health-Facilitated-Groups.aspx>).

In addition to standard supplies, the facilitator may want to provide the Personal Health Plan wallet card for Veterans to document goals that can be shared during provider appointments. The wallet card and other materials can be ordered at no charge from the VA Depot. Refer to the [list of available Whole](#)



[Health print products](https://dvagov.sharepoint.com/sites/VHAOPCC/SitePages/Available-Print-Products.aspx) (https://dvagov.sharepoint.com/sites/VHAOPCC/SitePages/Available-Print-Products.aspx).

## 6.2.2 Recruitment and Marketing for Group Participants

**There are many ways to recruit Veterans to participate in the *Introduction to Whole Health* and *TCMLH* programs.** Encourage staff referrals by reaching out to facility leadership (Primary Care, Specialty Care, and other services) to leverage existing initiatives. Over time, Veterans will spread the word to fellow Veterans based on their positive experience. Consider the following locations and modalities for sharing both verbal and written information about these groups:

- Contact the leadership team for Primary and Specialty Care to introduce the TCMLH Groups. This information could be presented at a staff meeting, to a smaller group representing Primary/Specialty Care, or in an email
- Partner with your local eligibility officer. Provide brochures, speak at a staff meeting, or offer to hold an *Introduction to Whole Health* session for their staff to provide them with a Whole Health experience
- Partner with your local Post-9/11 Military2VA Case Management Program Manager to identify forums to create awareness
- Collaborate with local VSO officers to identify forums for offering *Introduction to Whole Health*
- Determine if there is a welcome letter that is sent after a Veteran enrolls. Request that *Introduction to Whole Health* sessions and TCMLH Group information, flyers or brochures be included with these letters
- Create a simple communication, such as a one-page handout, “business card,” or brochure to allow Veterans who attended the sessions to share the program in their Veteran communities
- Request to add notes on appointment letters and reminder postcards
- Partner with NEO, PACT and other Departmental meetings
- Meet with internal stakeholders such as chaplains, patient advocates, etc.
- Offer sessions as part of formal programming in residential centers, domiciliaries, SAR RTP, etc.
- Attend community functions that have “Veteran Appreciation Nights,” such as baseball games or races
- Attend Veterans Day events, Homeless Stand Downs, Mental Health Summits, and/or other VA and community-sponsored events
- Contact public libraries, vocational education or technical programs (vo-tech), local colleges, and universities (especially schools with a Veteran Coordinator or Veteran Resource Center or Student Veteran Association chapter)
- Contact local television and radio stations
- Distribute print and social media evites

**To assist you with recruitment and outreach activities, utilize the resources available on the [OPCC&CT Communication Resources SharePoint page](https://dvagov.sharepoint.com/sites/VHAOPCC/SitePages/Communication-Resources-SharePoint-page)**

(https://dvagov.sharepoint.com/sites/VHAOPCC/SitePages/Communication-Resources-SharePoint-page). This site offers an array of helpful communication resources, as well as a variety of printed Whole Health products (general informational brochures, etc.) that can be ordered and/or downloaded.



## 6.3 Pathway Roles

**Offering Pathway programming from peers enables Veterans to learn strategies to enhance well-being outside of the traditional clinical setting, a process which may decrease demand on providers.**

Pathway roles may include Whole Health partners, Whole Health Group peer facilitators, Whole Health mentors and Whole Health coaches as Veteran peer facilitators. Additional roles that may offer services in the Pathway after receiving the requisite training include Peer Support Specialists, non-clinical Veteran employees, and registered Veteran volunteers. Descriptions of these positions are provided below, and a table summarizing the various Pathway roles and the required training for each is included in a table at the end of this section.

Many Pathway roles can be filled by volunteers, especially as peer facilitators for *Introduction to Whole Health* and *TCMLH* classes. In some cases, volunteers may be used prior to the hiring of dedicated Whole Health staff. Volunteers may be friends or family members of Veterans who express interest in supporting the work of Whole Health transformation, and they may have already participated themselves in Whole Health or patient-centered programs. Please refer to sections [5.2.4 Enlisting Volunteers to Support Whole Health](#) and [10.5 Contributions by Volunteers](#) for further information about the recruitment, training, and use of volunteers.

### 6.3.1 Whole Health Partners

The Whole Health partner is an official title within VA with a nationally classified position description. The role of Whole Health partners, who are ideally peer Veterans, is to actively engage with Veterans to help them understand the benefits of the Whole Health approach and what local Whole Health resources are available to support them. Whole Health partners may assist Veterans with a self-exploration process to help them become more active participants in their health care by introducing the use of a PHI and engaging in the personal health planning process. Whole Health partners utilize motivational interviewing, mindful awareness techniques and other skills to empower Veterans to take charge of their life and health. With the appropriate training, Whole Health partners may facilitate Whole Health groups such as *Introduction to Whole Health* and *TCMLH*. Refer to OPCC&CT's [Whole Health Partner Skills Training SharePoint](#) (<https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Whole-Health-Partner-Skills-Training.aspx>). Other duties may include:

- Welcome Veterans into the local system and orient them to Whole Health concepts
- Introduce Veterans to Whole Health and self-exploration utilizing tools such as the Personal Health Inventory and the Circle of Health
- Offer Veterans a variety of points of entry into Whole Health
- Coordinate and connect Veterans to resources, programs, coaching, etc. based on preferences
- Provide ongoing support to Veterans over time
- Become familiar with complementary and integrative health (CIH) approaches to share accurate and appropriate health information
- Facilitate *Introduction to Whole Health* and *TCMLH* group programs, once trained
- Conduct outreach to VSOs and other local Veteran support services

### 6.3.2 Whole Health Peer Facilitators

Whole Health peers are used to engage Veterans by facilitating *Introduction to Whole Health* and *TCMLH* courses. They encourage Veteran participation in other Whole Health programming. Whole

Health peers may play roles in crisis identification and complete warm handoffs to mental health services and substance abuse intervention programs.

Whole Health peer facilitators may be identified and selected through a variety of methods, such as through an application process or through nomination by a supervisor or the site's Center for Development and Civic Engagement. Whole Health peer facilitators are not required to have a prior mental health or substance use condition. When selecting Whole Health peer facilitators, the following qualifications, skills, and prerequisites should be considered:

- Previous experience teaching and/or facilitating groups professionally or privately
- Interest in integrative health education, or preferably, a personal experience with integrative health approaches
- Ability to speak positively about their own health journey and a willingness to share personal experiences with the group as appropriate
- Ability to read, apply, and follow the OPCC&CT [Whole Health Groups curriculum and supporting materials](https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Whole-Health-Facilitated-Groups.aspx) (https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Whole-Health-Facilitated-Groups.aspx)
- If volunteers do not have access to the electronic health record, provide supervision to ensure documentation or communication of Veteran encounters

Another valuable reference is the Whole Health Peer Facilitator Volunteer Position Description that is available in the [Whole Health Volunteer Positions SharePoint folder](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WHHumanResources/Forms/AllItems.aspx?viewid=81726be2%2D9a7a%2D41d3%2D9af2%2D6c06f7dc0d21&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FWHHumanResources%2FWH%5FPositions%2FVolunteer%5FPositions) (https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WHHumanResources/Forms/AllItems.aspx?viewid=81726be2%2D9a7a%2D41d3%2D9af2%2D6c06f7dc0d21&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FWHHumanResources%2FWH%5FPositions%2FVolunteer%5FPositions).

### 6.3.3 Peer Support Specialists (PSS)

Peer Support Specialists (PSS) are VA employees recovering from mental health and/or substance use disorders. PSS are trained to share their recovery experiences and provide supportive services to other Veterans who are also in recovery, helping these Veterans to achieve their goals in pursuit of a healthy life. PSS build rapport and work with Veterans to develop a personalized journey of recovery and may share their own personal recovery story with the Veteran as appropriate. The PSS makes appropriate referrals to Mental Health and Whole Health services, including PCMHI and MH-WHS and supports integration of MH-WHS programming.

Nationally, the Office of Mental Health and Suicide Prevention and OPCC&CT have agreed that PSS can provide Whole Health non-clinical group or individual sessions after receiving the necessary training. Refer to the [national memo regarding PSS and Whole Health services](https://dvagov.sharepoint.com/:b:/s/VHAOPCC/WH-Implementation/EUumLDOTdUxJiQZ4RBMXl8IB8hIhgV4mAoLsW_el-qVTgQ?e=YBhluw) (https://dvagov.sharepoint.com/:b:/s/VHAOPCC/WH-Implementation/EUumLDOTdUxJiQZ4RBMXl8IB8hIhgV4mAoLsW\_el-qVTgQ?e=YBhluw) for further information.

### 6.3.4 Whole Health Mentors

Whole Health mentors play a critical role in advancing Whole Health by ensuring the fidelity and quality of Whole Health services provided to Veterans. It has been reported that Whole Health Pathway staff

(Whole Health partners, Whole Health coaches and Whole Health facilitators) experience a high rate of turn over. Whole Health mentors can help minimize turn over by providing support for these critical positions. Some of the functions of a Whole Health mentor include providing local training and mentoring support to newly hired Whole Health Pathway staff, fostering integration within the Whole Health Pathway, ensuring a seamless transition for Veterans engaged in Whole Health Pathway services, and educating clinical care teams and Well-being Programs staff on the Whole Health Pathway to further integrate all three components of the Whole Health System.

#### 6.3.5 Whole Health Coaching in the Pathway

Veterans engaged in Pathway offerings with Whole Health Partners and group facilitators may identify areas of focus best supported by Whole Health coaching, or by participation in well-being programming for a deeper exploration and skill building in support of their mission, aspiration and purpose. Whole Health coaches support Veterans in mobilizing internal strengths and external resources to develop strategies for making sustainable, healthy lifestyle behavior changes. Referrals from Pathway programming can be made to individual or group coaching, either in person, telephonically or via telehealth. **Note: If the Whole Health coach is also a Veteran themselves, they may facilitate Introduction to Whole Health and TCMLH groups. TCMLH groups are not considered coaching groups.**

#### 6.3.6 Personal Health Planning in the Pathway

Through individual engagement with Whole Health partners, peers, or volunteers, or through participation in facilitated TCMLH group sessions, Veterans have an opportunity to begin the personal health planning process by completing the PHI. In this process, Veterans explore:

- “What matters” to identify their mission, aspiration and purpose for their health and well-being
- Areas of self-care that support health and well-being, and identify potential areas of strength and opportunity
- Next steps or personal goals for health and well-being

This process is summarized in a personal health plan (PHP) that Veterans can share with health coaches and providers to develop shared goals.

Table 5: Pathway Role Details

Role	Provided By	Training Required	Primary Tasks
<b><i>Introduction to Whole Health</i> facilitator</b>	Non-clinical Veteran staff, Whole Health partners, Peer Support Specialists, registered Veteran volunteers	2-hour virtual training from OPCC&CT to learn how to deliver the <i>Introduction to Whole Health</i> session  Available in Talent Management System (TMS) course #35647	Facilitate <i>Introduction to Whole Health</i>  Engage with participants  Introduce participants to Whole Health concepts  Provide a Whole Health experience  Encourage participation in <i>TCMLH</i> and other local programming
<b>Taking Charge of My Life and Health (TCMLH) facilitator</b>	Non-clinical Veteran staff, Whole Health partners, Peer Support Specialists, registered Veteran volunteers	3-day in-person or 5-day virtual TCMLH Facilitator training from OPCC&CT or instructor trained by OPCC&CT in the TCMLH Train-the-Trainer course	Facilitate <i>TCMLH</i> groups  Engage with participants  Introduce participants to Whole Health concepts  Provide a Whole Health experience

Role	Provided By	Training Required	Primary Tasks
<b>Whole Health partner</b>	Ideally Veteran employees meeting the qualifications as outlined in the Whole Health partner position description	<p>TCMLH 3-day Facilitator Training and/or VA Whole Health Coaching training</p> <p>2-day in person or 3-day virtual Whole Health Partner training course post completion of TCMLH Facilitator Course and/or the Whole Health Coaching Course</p>	<p>Recruit Veterans to Whole Health and create awareness of benefits of Whole Health</p> <p>Provide ongoing support to Veterans over time</p> <p>Engage Veterans briefly one-on-one regarding their PHP and assist with getting requested support</p> <p>Conduct outreach to VSOs and other local Veteran services</p>
<b>Whole Health mentor</b>	<p>VA staff who have a strong interest and enthusiasm for Whole Health and want to support its evolution</p> <p>Individuals with attitude and ability to become successful mentor of Whole Health Pathway staff</p> <p>VA staff who have designated time to further enhance the skills of Whole Health Pathway staff</p>	2 ½ - day in person or 4-day virtual training, designed to empower and equip participants (mentors) to support and enhance the services provided by the Whole Health Pathway including Whole Health coaches, TCMLH Facilitators and Whole Health partners	<p>Know the services provided via the Whole Health Pathway, and the unique skills and challenges required for successful delivery</p> <p>Provide ongoing skill training and mentoring to staff providing Whole Health Pathway services</p> <p>Ensure fidelity of the model through effective feedback with ongoing observations of staff</p> <p>Lead regular meetings that further enhance the learning of staff</p>

## 6.4 Organizational Awareness of the Pathway

Creating awareness across the organization of Pathway offerings requires effective sponsorship by engaged, active and visible leadership. **Organizational awareness can be facilitated by identifying a leader to be the executive sponsor for Pathway offerings, and through the development of a communication strategy with effective messaging for a variety of audiences.** Individuals responsible for coordinating Pathway programming can provide talking points for the sponsor and work to get the Pathway on the agenda of various leadership and staff level meetings.

All staff from across the organization are potential referral sources to help get Veterans into the Pathway. Both clinical and administrative staff need to have an awareness and understanding of what the Pathway is and how Veterans benefit from the services. These referral sources frequently gain a better understanding of the benefits of Pathway programming when they experience Whole Health on a personal level. This can be done by offering a customized Introduction to Whole Health session based on their time availability, or by requesting time in a staff meeting to explain Whole Health. This process of focusing on their own well-being and completing the PHI helps to create a personal experience that can make staff more likely to refer Veterans to the Pathway groups.

## 6.5 Connecting the Pathway to other Components of the Whole Health System

**Veterans may enter the Whole Health System (WHS) at any point.** For example, a Veteran already established in PACT or Mental Health may be referred to the Whole Health Pathway or Well-being Programs once the site develops these components of the WHS. **A Veteran's involvement with Whole Health is considered cyclical, rather than being a linear process,** so the Veteran may benefit from the various aspects of the WHS multiple times. This fluid experience for the Veteran requires that the various components of the WHS be seamlessly connected to support the Veteran's health and well-being. This includes incorporation of the Veterans PHI and PHP, which may be initiated in the Pathway, into all aspects of the WHS so that the Veterans' MAP and goals "follow" them throughout their well-being journey.

It is important to ensure that Pathway team members are knowledgeable about the services and programs offered in the Well-being Programs, Whole Health coaching and Whole Health Clinical Care. Staff must also understand the process/mechanism for referral to these other offerings to facilitate the transition for the Veteran.

Regular committee or steering council meetings with representatives from each of the WHS components also allows for dialogue on improving efficiencies, addressing barriers to seamless connections within the WHS, and evaluating the effectiveness of linkages between the Pathway and other Whole Health System components. Policies and processes should be established to promote a seamless connection with the Well-being and Whole Health Clinical Care components.

## 6.6 Expansion of the Pathway

Once the Pathway is established at the initial location and as resources allow, consider expanding Pathway programming into other sites of care and community-based settings. This will allow for enhanced access by rural Veterans, and to those Veterans not coming to the main care location(s) on a routine basis. Use of telehealth and similar technology platforms are also helpful in reaching these

Veterans remotely. More information about implementing TeleWholeHealth can be found in section [5.1.1.2 Telehealth](#). Likewise, expanding Pathway groups to VSO locations and other community partners such as YMCAs, Vet Centers, vocational educational or technical programs, local colleges and universities increases the likelihood of Veterans' exposure to Whole Health. Refer to section [10.4 Local Partnerships for Provision of Whole Health Approaches](#) for guidance on establishing these relationships.

## Resources

[Pathway Domain SharePoint Document Library](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Pathway_Domain/Forms/AllItems.aspx) (https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Pathway\_Domain/Forms/AllItems.aspx)

[Whole Health Human Resources SharePoint Document Library](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WHHumanResources/Forms/AllItems.aspx)  
(https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WHHumanResources/Forms/AllItems.aspx)

[OPCC&CT Communication Resources SharePoint page](https://dvagov.sharepoint.com/sites/VHAOPCC/sitepages/communication-resources.aspx)  
(https://dvagov.sharepoint.com/sites/VHAOPCC/sitepages/communication-resources.aspx). This site offers an array of helpful communication resources, as well as a variety of printed Whole Health products (general informational brochures, PHI forms, wallet cards, etc) that can be ordered and/or downloaded.

[Whole Health Facilitated Groups Courses \(TCMLH\)](https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Whole-Health-Facilitated-Groups.aspx)  
(https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Whole-Health-Facilitated-Groups.aspx), AND TMS course #35647

[Whole Health Partner Skills Training](https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Whole-Health-Partner-Skills-Training.aspx)  
(https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Whole-Health-Partner-Skills-Training.aspx)

[Whole Health Mentor Course](https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Whole-Health-Mentor-Course.aspx)  
(https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Whole-Health-Mentor-Course.aspx)

[OPCC&CT Executive Order Guidance for curriculum, implementation logistics & schedule of virtual training for Introduction to Whole Health programs](https://dvagov.sharepoint.com/sites/VHAOPCC/2018ExecutiveOrderGuidanceTraining/Forms/AllItems.aspx)  
(https://dvagov.sharepoint.com/sites/VHAOPCC/2018ExecutiveOrderGuidanceTraining/Forms/AllItems.aspx)

## 7. Well-being Domain

The Well-being Program (WBP), as illustrated in the overview of the Whole Health System (WHS) model in section 2. Whole Health System: Overview of this *Guide*, is one of three major components of the WHS. WBPs should be available to all Veterans, across all service lines, regardless of diagnosis or disease status. **Through well-being programming, Veterans are equipped with skills to optimize their health and well-being.** In this section, the structure of the WBP is outlined, and guidance is provided on how to plan for WBP offerings, and on how to incorporate the Personal Health Inventory (PHI) and Personal Health Plan (PHP) process into the WBP.

The implementation of WBPs requires careful planning in terms of strategic communication and outreach, logistics, and resource management. To that end, the *Designation Framework for Whole Health Implementation (Designation Framework)* clearly outlines accomplishments facilities can focus on to ensure they are building a sustainable WBP throughout the tiered phases of implementation (from Preparation to Full implementation). In the Preparation Phase, sites are actively designing and building agile WBP that equip Veterans with the skills and support for self-care and well-being. By the time facilities reach Full implementation, they are offering a vibrant and vital WBP which equip Veterans with the skills for self-care in dynamic operations that are well-utilized and accessible to Veterans via multiple, supportive connections and partnerships. For more details about the accomplishments occurring within each implementation phase, review the Well-being section of the [Designation Framework](https://dvagov.sharepoint.com/:w:/s/VHAOPCC/EUdWEp9OfqtGt3wL4-VZ3mIBIRzn6chrEYAyqfc7ffTdyw?e=flmsq5) (<https://dvagov.sharepoint.com/:w:/s/VHAOPCC/EUdWEp9OfqtGt3wL4-VZ3mIBIRzn6chrEYAyqfc7ffTdyw?e=flmsq5>).

### 7.1 Core Offerings

**The core offerings of a WBP, as illustrated in the figure below, include:**

1. **Complementary and integrative health (CIH) and other well-being approaches** (yoga, meditation, adaptive sports, etc.)
2. **Well-being skill building classes** organized into class tracks (Power of the Mind, Moving the Body, etc.)
3. **Whole Health coaching**



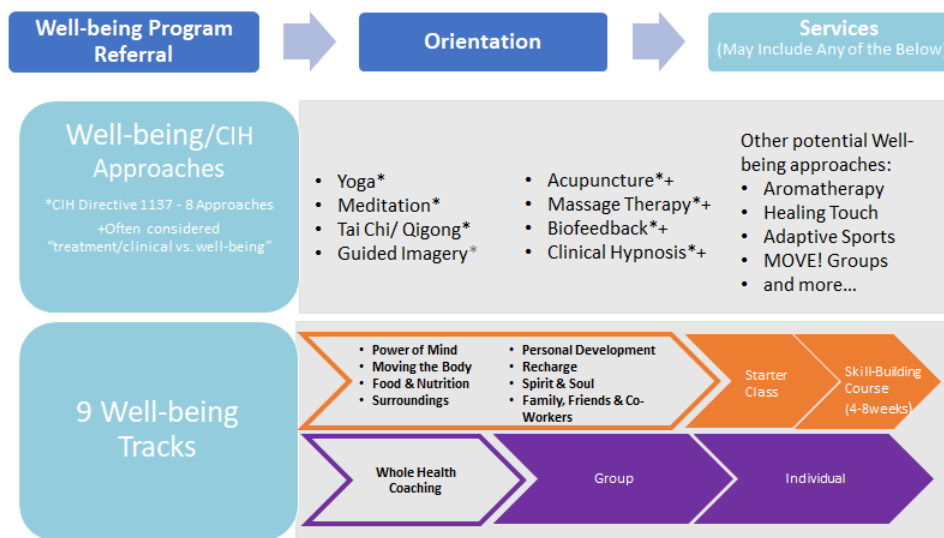


Figure 3: Well-being Program Structure

The WBP structure is designed to build upon and incorporate existing health education and health promotion programs such as creative arts, adaptive sports, and programming developed by program offices such as Nutrition and Food Services or the National Center for Health Promotion and Disease Prevention (NCP), e.g., Healthy Teaching Kitchens, Gateway to Healthy Living, and the Veterans Health Library. Sample WBP schedules can be found in the [Well-being Document Library](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WellBeing_Domain/Forms/AllItems.aspx?viewid=62b2fa37%2D1568%2D4295%2Da63c%2D6d0d74c5f9aa&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FWellBeing%5FDomain%2FMarketing) ([https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WellBeing\\_Domain/Forms/AllItems.aspx?viewid=62b2fa37%2D1568%2D4295%2Da63c%2D6d0d74c5f9aa&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FWellBeing%5FDomain%2FMarketing](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WellBeing_Domain/Forms/AllItems.aspx?viewid=62b2fa37%2D1568%2D4295%2Da63c%2D6d0d74c5f9aa&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FWellBeing%5FDomain%2FMarketing)).

There are three (3) main steps to establish a WBP at a facility:

1. Determine which CIH approaches, health coaching, and well-being classes the site (and Veteran population) can support
2. Develop mechanisms for broad access to all Veterans
3. Develop ways to communicate about the programming to Veterans and providers

These steps will be discussed in detail throughout the remainder of this chapter.

## 7.2 Planning Well-being Programs

There are many potential WBP offerings, and each should be considered alongside the Veteran to identify the best choice for them. Well-being classes and health coaching are a big part of WBPs in addition to various CIH and Whole Health approaches.

In determining what CIH approaches to stand up or structure as “anchor” services, please consider that the **VHA requires eight evidence-based CIH approaches to be offered either within the facility (in person or delivered via telehealth) or the community** (VHA Directive 1137: Provision of Complementary and Integrative Health) and are ideal for WHS implementation. **NOTE: not all CIH approaches are used for general well-being; rather, some are considered CIH treatment.** However, all List 1 CIH approaches are listed here:

- Acupuncture
- Tai Chi
- Yoga
- Guided imagery
- Clinical hypnosis
- Biofeedback
- Massage therapy
- Meditation

In some sites, massage therapy and acupuncture services may be offered primarily within Whole Health Clinical Care due to the treatment nature of these services; in other sites, they may be largely based in the WBP. Similarly, although Tai Chi, yoga, and meditation will be offered primarily within WBPs in most sites, they may also be offered in other departments (e.g., mental health, pain clinic, Community Living Centers). More information about each of the eight required CIH approaches can be found on the [IHCC SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC) (<https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC>), where the full list is updated and maintained by the Integrative Health Coordinating Center (IHCC). The site also houses [CIH Policy information](https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Policy.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Policy.aspx>), including VHA Directive 1137 and other guidance.

#### 7.2.1 Identifying Gaps in Service

Before beginning to offer services under the WBP umbrella, it is important for sites to perform a gap analysis comparing existing services with mandatory requirements of a WBP [i.e., WBP class tracks, CIH and other well-being approaches and Whole Health coaching]; facility, VISN and national strategic plans; and other national drivers such as Executive Decision Memos (EDMs), High Reliability Organization (HRO) and directives.

#### **Some questions sites can ask when identifying gaps in existing services may include:**

- Which CIH and other well-being approaches does the site already offer? Are they available to all Veterans, or only to Veterans in specific clinics, units or locations? Which ones?
- Are there any already-established plans to make additional CIH and well-being approaches available?
- Does the site have adequate and dedicated staff who can be trained in well-being approaches and coaching, or will additional staff need to be hired?
- Which well-being approaches are currently available through the community?
- Are there any local subject matter experts with a background in a well-being modality who are not yet providing that service to Veterans?
- Does the site already offer Whole Health coaching, and if not, what are the plans to offer it in the future?
- What specific obstacles do you foresee in offering the required well-being approaches and Whole Health coaching to Veterans? How can those obstacles be addressed?
- Which services can be offered through alternative delivery options (telehealth, online classes/resources, etc.)?

Sites may choose to work with their Field Implementation Team (FIT) Consultant to help identify additional gaps and to create a short- and/or long-term plan to begin offering WBPs.

**When considering which CIH modalities to offer, sites should keep in mind that the eventual goal is to offer all of the evidence-based CIH approaches covered under VHA Directive 1137 on-site, virtually using telehealth technology, and/or via community referral to match Veteran demand, whether through WBP or Whole Health Clinical Care programs.**

### 7.2.2 Service Delivery and Scheduling Options

Many of the WBP services can be offered in individual sessions or group format, and this flexibility is important to consider when planning your initial WBP offerings. Decisions on how to balance individual vs. group services will need to consider space availability, staff availability, and expected patient volume, as well as some specific aspects of individual and group sessions. Group sessions afford flexibility when structured as either drop-in groups offered on a first come/first served basis or closed groups offered through appointment, which can increase access. Additionally, the group session experience can provide potentially therapeutic relationships among Veterans participating in these services.

Be flexible in balancing group vs. individual care as you learn more about the level of demand for each of the WBP offerings in your Veteran population. In some cases, there may be a demand for groups for specific populations (e.g., Yoga for Women, Yoga for Military Sexual Trauma). If this is the case, sites should determine how best to address this need and make every effort to provide for these Veterans. Regardless of the services provided, close collaboration between the WBP and Whole Health Clinical Care, as well as clear and consistent documentation of provided services, are essential to ensure a coordinated approach for the Veteran. Additional tips for WBP delivery are described in the table below.

*Table 6: Tips for WBP Delivery*

<b>Constructing Schedules for Well-being Programming</b>
Clearly outline where and when each service will be provided and keep this consistent. Frequent schedule changes (date & time, location, or cancellations), particularly in the beginning of establishing a program, will make it difficult to recruit Veterans, to establish trust with the Veteran community, and to convey consistency and legitimacy among other services in the facility (i.e., your referral sources).
Referrals will diminish if services are offered inconsistently or they are difficult for Veterans to find or attend.
It is always good to have back-up providers and instructors. Canceling drop-in classes is difficult because Veterans are not pre-scheduled for classes. If your provider is out unexpectedly (which can happen more frequently with volunteers), it is always helpful to have someone available to cover.
As the WBP grows in size and scope, consider offering classes at a variety of times, such as late afternoon, and in easy-to-find locations, including virtually. This will help accommodate Veterans who are unable to travel to a facility during regular business hours and/or those Veterans who live a considerable distance from the main facility (vs. a CBOC).

Constructing Schedules for Well-being Programming
Scheduling options should reflect the different points of entry used by Veterans to access well-being services (i.e., direct scheduling, scheduling through consults, etc.). Lack of available staff to enter the appointment(s) should not impede the Veteran from attending a class or receiving well-being and CIH services.

In some cases, services offered within the WBP can also be offered to staff in specific staff classes, which can increase awareness and understanding of these services and support employee resiliency. Keep in mind, though, that because of Veterans Equitable Resources Allocation (VERA) and financing issues, in some facilities this may be better provided in conjunction with Employee Whole Health (EWH) services. Please refer to section 9. Employee Whole Health Domain of this *Guide*.

#### 7.2.2.1 Virtual Options

Transitioning from delivering in-person well-being programming, either individually or in a group, to the virtual platform requires a new type of planning and setup for both provider and Veteran(s). Screening considerations for Veterans receiving well-being services relate to the Veteran's health, safety, and emotional functioning – can they effectively participate? Veterans with physical, medical and psychiatric conditions may require special attention to ensure they are comfortable and supported during telehealth services. Some questions to consider include:

##### Physical–

- Do they have the physical comfort and stamina needed to participate in a virtual session?
- Do they have experience with the well-being service?
- Would they benefit from an in-person introductory class?

##### Cognitive –

- Can they follow the direction provided within the service?

##### Emotional –

- Are they able to manage strong emotions which may arise during a virtual session?
- What support systems are in place if they leave the session feeling activated, fatigued, confused, or anxious?

##### Technology and Space--

- Will this be one-on-one or a group session?
- Does the Veteran have technology resources for video conferencing?
- Consider the Veteran's comfort and ability in using technology – can they effectively use it, or will it detract from the experience?
- Does the Veteran have enough physical space to receive and complete the well-being service?

For more specific information about the use of telehealth and virtual delivery platforms, please refer to section 5.1.1.2 Telehealth of this *Guide*.

### *7.2.2.2 Well-being in the Community*

#### **Care in the Community (CITC)**

VHA Directive 1137 outlines the provision of CIH in VHA and requires facilities to offer eight CIH approaches which show evidence of promising or potential benefit if it is a part of the Veteran's care plan. Out of this list of approaches, meditation, yoga, Tai Chi, and guided imagery are considered well-being approaches. If facilities do not have access to these (through on-site, facility partnerships, or virtual means), Veterans are entitled to access this type of care through Care in the Community (CITC) funds. As VHA transitions to the new CITC network contract, sites will be able to access CIH approaches through the third-party administrator's established network of providers. The new contract includes acupuncture, mindfulness-based stress reduction (MBSR), Tai Chi, massage therapy, clinical hypnosis, and biofeedback. While yoga and guided imagery are not yet a part of the national contract, sites are still able to create local Veteran Care Agreements with vendors using CITC funds or use virtual means to offer resources to Veterans. To answer additional questions, the IHCC has created a CITC fact sheet which can be found on the IHCC SharePoint, [CIH site](https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/About.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/About.aspx>).

#### **Community Partnerships, Volunteers, and Vet Centers**

The WHS represents a transformation in the healthcare delivery model with a strong emphasis on collaboration and partnership with the community. This can create a great opportunity to recruit community volunteers to provide well-being approaches or to create Memoranda of Understanding/Agreement (MOU/As) with organizations who care deeply for providing support for Veterans. VHA has created national MOUs with several organizations, including YMCA. Due diligence should be completed before agreeing to collaborate, partner or establish a MOU/A with an outside entity. In addition, many well-being approaches such as yoga, meditation, and Tai Chi are sometimes volunteer led. If bringing a trained well-being provider in as a volunteer, you will want to work with the site's Center for Development and Civic Engagement. Contracting/paying for services would require a different process. Providers should be vetted for their appropriate training/credentials/etc., regardless of whether it is a volunteer or paid service either on-site or off-site.

Many Veteran Readjustment Counseling Centers (Vet Centers) are beginning to offer well-being related offerings. OPCC&CT has partnered with Vet Centers to implement Whole Health in all 300 community-based counseling centers, and training of 30 Vet Center Whole Health implementation staff across all regions was conducted in June 2019. Since that time, Vet Centers have developed a Whole Health Community of Practice call for all regions to report implementation status, ask questions, share best practices, and for skill building and development training. Some Vet Centers are beginning to reach out to VAMC's to build local Whole Health relations to improve care for Veterans. Please reach out to a [Vet Center](https://www.vetcenter.va.gov/) (<https://www.vetcenter.va.gov/>) in your region to foster that connection and build a collaborative approach to Whole Health.

For more information about MOU/As, the use of volunteers in Whole Health (including sample position descriptions), and Vet Centers, please refer to:

- [Volunteer Positions SharePoint folder](https://dvagov.sharepoint.com/:f:/r/sites/VHAOPCC/WH-VolunteerPositions)  
([https://dvagov.sharepoint.com/:f:/r/sites/VHAOPCC/WH-](https://dvagov.sharepoint.com/:f:/r/sites/VHAOPCC/WH-VolunteerPositions)

Implementation/WHHumanResources/WH\_Positions/Volunteer\_Positions?csf=1&web=1&e=aB  
ymue)

- Sections 5.2.4 Enlisting Volunteers to Support Whole Health and [10.2.1 Vet Centers](#) of this *Guide*

### 7.2.3 Staffing Well-being Programs

The most important aspects of delivering WBP services at your site are the individuals who will provide the care. Ideally, you can identify providers already within the VA who have the skills, training, and passion for well-being approaches. As you begin the staffing process, consider surveying current staff for expertise and interest in these areas. For example, you may already have a Registered Dietitian specialized in Integrative/Functional Nutrition, a Psychologist with extensive mindfulness training, or a Social Worker who is also a yoga instructor. As you identify these staff members, work with them and their supervisors to explore sharing time among programs. Obtaining an informal MOU/A with the supervisor is suggested so the staff member has protected time for providing WBP services. In addition, staff should be providing these services within their scope of practice. For example, if providing yoga is NOT in their scope, then they would need to provide that outside of their tour as a volunteer.

**If there are current VA providers interested in learning specific CIH and other well-being approaches, cross-training these providers can help support service delivery** as you launch WBPs, and over time, these providers can serve as valuable “back-fill” when short-staffed or provide “surge” support if you expand CIH and other well-being offerings. It is important that both the provider and their supervisor clearly understand the time commitment for both the training and the use of the skills in the WBP following the training, and that the services provided are within the scope of practice of that provider. VA is offering some well-being provider skills trainings internally including health coaching, VA CALM Mindfulness Facilitator training, and guided imagery (online). Additionally, more clinical trainings are being offered for clinical hypnosis and battlefield acupuncture.

If your facility does not have many providers trained in WBP services, explore and expand community partnerships that do have these types of services (e.g., Vet Centers, YMCAs, VSOs). Key factors to consider when choosing how best to provide WBP services include:

- Site funding for new staff
- Training of current staff in well-being approaches
- Ability for existing staff to coordinate services
- Degree of quality control desired for the care being provided
- Ability to provide sufficient access given staffing or space constraints at the site
- Availability of providers in the community

For more information about Whole Health staffing, please refer to section 5.2 Staffing [of this Guide](#). In addition, the [Whole Health Positions SharePoint](#) (<https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WHHumanResources/Forms/AllItems.aspx?csf=1&web=1&e=npLzfA&cid=dfc5b555%2D5baf%2D4721%2D92b5%2Dca7fc0319d5&RootFolder=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FWHHumanResources%2FWH%5FPositions&FolderCTID=0x0120007CAC879BF5A7C34AA7EF301B453691B4>) houses position descriptions and hiring documents for a variety of Whole Health positions.

#### 7.2.3.1 Whole Health Coaches in Well-being

If possible, your site should hire (or transfer over) one or more Whole Health coaches to lead the well-being classes, coaching groups, and individual coaching sessions. Whole Health coaches may function in a variety of settings within the Whole Health System depending on local organizational structures. They may be integrated with PACT, CBOC, telehealth, and community outreach operations.

Whole Health coaches work with individuals and groups throughout the site in a Veteran-centered process to facilitate and empower Veterans to develop and achieve self-determined goals related to health and well-being. Whole Health coaches support Veterans in mobilizing internal strengths and external resources to develop strategies for making sustainable, healthy lifestyle behavior changes and more effectively managing chronic disease. While Whole Health coaches do not diagnose conditions, prescribe treatments, or provide psychotherapeutic interventions, they provide expert guidance and may offer resources from nationally recognized authorities.

The Whole Health coach works with the Veteran to complete a PHP with established SMART goals and documented follow-up on SMART goals. The Whole Health coach makes appropriate referrals of the Veteran to Pathway, Well-being Programs and Whole Health Clinical Care programming. Whole Health coaches may provide non-count individual or group coaching in person, telephonically or via telehealth (if not a clinician such as an LVN/LPN). Certified Whole Health coaches may provide individual or group coaching in person, telephonically or via telehealth within count clinics.

The **Health and Wellness Coach is an official position title within VA with a nationally classified position description**. VA providers cross-trained in Whole Health coaching skills are ideal candidates for leading classes or filling this position (OPCC&CT offers Whole Health Coaching Training). In addition, the **Certified Health and Wellness Coach has received the National Board for Health & Wellness Coaching (NBHWC) certification**. The certified coach provides guidance and mentoring to partners, peers, other Whole Health coaches, the Whole Health team and other services on the delivery of Whole Health coaching at the site. The certified coach manages his/her own count clinic productivity (face-to-face or via telehealth) in a manner that is fiscally beneficial to the facility. Note: If the certified coach is also a Veteran themselves, they may facilitate *Introduction to Whole Health* and *TCMLH* groups.

#### 7.2.4 Credentialing Well-being Providers

It is important to make sure well-being providers have the proper training to provide these approaches. The National VA Credentialing Office has given guidance on credentialing and privileging and recommends that facilities develop their own local procedures and policies for vetting non-licensed, non-credentialed providers of health and well-being approaches. Some facilities may choose to have additional privileges added to VA employees who are licensed, qualified health professionals and who are providing well-being approaches as an additional duty. This is a facility-level decision and is not mandatory.

**OPCC&CT has developed minimum standards for the evidence-based CIH approaches covered under VHA Directive 1137. This guidance, along with nationally standardized position descriptions, is located in the [Whole Health Positions SharePoint folder](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WHHumanResources/Forms/AllItems.aspx?viewid=81726be2%2D9a7a%2D41d3%2D9af2%2D6c06f7dc0d21&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FWHHumanResources%2F)** (<https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WHHumanResources/Forms/AllItems.aspx?viewid=81726be2%2D9a7a%2D41d3%2D9af2%2D6c06f7dc0d21&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FWHHumanResources%2F>)



2FWH%5FPositions). Please contact your site's FIT consultant for additional resources on position descriptions and functional statements.

Please note, the guidance above related to credentialing and privileging does not apply to CIH treatment approaches such as acupuncture, massage therapy, biofeedback, clinical hypnosis, and chiropractic, where it is necessary to have licensed or qualified providers. There are qualification standards and functional statements for acupuncture and massage therapy providers. Many facilities require additional privileges for biofeedback and clinical hypnosis, and the IHCC has outlined minimum standards for providers of these approaches as well. Additional information on setting up local validation procedures, including examples from VA health care systems around the country, can be found on the [IHCC Sharepoint](https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC) (<https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC>).

**In considering who can provide well-being approaches, it is also important to think about existing employees' scopes of practice and to make sure they are broad enough to cover these.** State licensing boards determine scope of practice for professionals based on training and competencies. Employees should check with their state boards on scope of practice, and if they are not able to provide a clear yes or no decision, facility leadership will need to determine if delivery of the CIH approach in question is allowable. The Office of Social Work Services and the Office of Nursing Services have released memos to guide decision-making and can be found in the [CIH Policy section of IHCC SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Policy.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Policy.aspx>).

### 7.2.5 Veteran Access to Well-being Programs

**The WBP should be easy to access for all Veterans. Potential mechanisms for access include:**

- 1. Self-referral**
- 2. Direct scheduling**
- 3. Consult**
- 4. Additional signer**

Ideally, all WBPs will include a self-referral option. When using consults, please keep in mind that VHA policy governs all aspects of consult management, such as appropriate timeframe for initial contact to be made and for completion to occur. A WBP consult can be available to all providers, including Whole Health coaches, Whole Health partners, and Whole Health peers. When using the consult for medical clearance, alert the Veteran's Primary Care Physician (PCP) or another medical provider for appropriate documentation.

Although a Veteran may be referred for a specific WBP service, it is essential that the Veteran can develop and design their own plan for engaging with the Well-being programming. An orientation session can support this process of Veteran-centered, Veteran-driven care within the WBP.

An orientation specific to well-being programming could include information about the program offerings, understanding how to get involved, and aligning program use with the Veteran's PHP. The number of orientation sessions needed weekly will be determined by the volume of referrals to the program. If Veterans are accessing programming through a consult, a WBP orientation can aid in consult completion since completion or "closing" the consult can be done by writing a consult note for orientation attendance.



Alternatively, a site can develop a WPB introductory class with education and assessment (i.e., physical clearance to participate in activities such as yoga) leading to referral to subsequent WBP class tracks, CIH and other well-being approaches, and/or health coaching. This class can be complemented by an online portal with educational materials and media for self-directed skill building.

#### **A Word on Orientations**

**We recognize that this Guide describes two orientations – (1) Pathway: *Introduction to Whole Health* classes and (2) WBP Orientation. Depending on what makes the most sense for your facility, these orientations could be separate or combined. Thus, the field has flexibility in developing the structure that makes the most sense for the Veterans they serve. When a site does choose to introduce Veterans to well-being programming through an orientation, the effectiveness of the orientation should be evaluated and continually refined.**

Regardless of how Veterans access WBP offerings at a site, it is important to develop ways to implement and evaluate Veteran feedback so that the site's WBP offerings can meet the Veteran's needs based on their MAP and PHP. **Here are some possible methods that a site can use to collect feedback:**

- Veteran Family Advisory Council
- Whole Health Veteran Advisory Council
- Surveys with *TCMLH* and other Veteran groups
- Collaborate with local Patient/Veteran Experience program staff
- Whole Health tables at farmer's markets, building entry ways, etc.
- Collaborate with Peer Support Specialists

It may be helpful to have the site's Whole Health POC and/or a workgroup collect and evaluate data received from Veterans. A site's Whole Health steering committee can also assist in reviewing and evaluating Veteran feedback to continually improve access and program offerings. Additional information about evaluation can be found in sections 7.4 Evaluating and Tracking Well-being Programs and [11. Evaluating Whole Health Implementation](#) of this *Guide*.

##### [7.2.5.1 Addressing Barriers to Access to Well-being Programming](#)

When evaluating access to WBPs, a site should identify methods to reduce barriers to accessing services. These methods may include direct scheduling as available or return-to-clinic (RTC) into WBP services vs. consult generation and management. Likewise, a site can develop virtual WBP offerings, as well as community partnerships for referral to well-being programming or for self-directed engagement in well-being practices in the community. Please see section 7.2.2 Service Delivery and Scheduling Options.

## [7.3 Launching and Delivering Well-being Programs](#)

### [7.3.1 Guidance for Implementing Mandatory CIH Approaches](#)

VHA Directive 1137 requires eight evidence based CIH approaches be made available to Veterans across the system, either within a VA medical facility (or via telehealth technology) or in the community if the approach is part of the Veteran's care plan. To see a list of **current approaches covered under the Veterans Medical Benefits Package**, visit the [CIH Policy section of the IHCC SharePoint](#)

(<https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Policy.aspx>). For detailed implementation guidance on the required well-being CIH approaches, please use the links below to access the IHCC SharePoint and start with the “Starting a Program” folder on each page. NOTE: not all CIH approaches are used for general well-being; rather some are considered CIH treatment, however links to all CIH approaches are listed here:

- 1) [Acupuncture \(including Battlefield Acupuncture- BFA\)](https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Acupuncture.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Acupuncture.aspx>)
- 2) [Biofeedback](https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Biofeedback.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Biofeedback.aspx>)
- 3) [Clinical hypnosis](https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Clinical-Hypnosis.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Clinical-Hypnosis.aspx>)
- 4) [Guided imagery](https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Guided-Imagery.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Guided-Imagery.aspx>)
- 5) [Massage therapy](https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Message-Therapy.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Message-Therapy.aspx>)
- 6) [Meditation](https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Meditation.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Meditation.aspx>)
- 7) [Tai Chi/Qigong](https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Tai-Chi---Qi-Gong.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Tai-Chi---Qi-Gong.aspx>)
- 8) [Yoga](https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Yoga.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Yoga.aspx>)

As discussed previously in this chapter, at some sites massage therapy and acupuncture services may be offered primarily within Whole Health Clinical Care due to the treatment nature of these services. At other sites, they may be based in both the WBP and Whole Health Clinical Care (WHCC). Similarly, although Tai Chi, yoga, and meditation will be offered primarily within the WBP at most sites, they may also be offered in other departments (e.g., mental health, pain clinic, Community Living Centers, etc.).

For further information on the above approaches, please see the:

- [IHCC SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC) (<https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC>)
- [Passport to Whole Health](https://dvagov.sharepoint.com/sites/VHAOPCC/Shared%20Documents/Forms/AllItems.aspx?id=/sites/VHAOPCC/Shared%20Documents/Communications/Education%20Print%20Products/Passport%209-2020%20for%20printing%20only.pdf&parent=/sites/VHAOPCC/Shared%20Documents/Communications/Education%20Print%20Products) (<https://dvagov.sharepoint.com/sites/VHAOPCC/Shared%20Documents/Forms/AllItems.aspx?id=/sites/VHAOPCC/Shared%20Documents/Communications/Education%20Print%20Products/Passport%209-2020%20for%20printing%20only.pdf&parent=/sites/VHAOPCC/Shared%20Documents/Communications/Education%20Print%20Products>)
- [IHCC FAQ- Power Apps](https://apps.gov.powerapps.us/play/4b106e97-2c02-4484-a0cb-dc0bfe8695fd?tenantId=e95f1b23-abaf-45ee-821d-b7ab251ab3bf) (<https://apps.gov.powerapps.us/play/4b106e97-2c02-4484-a0cb-dc0bfe8695fd?tenantId=e95f1b23-abaf-45ee-821d-b7ab251ab3bf>)

For more information on guidance for providing chiropractic care, please visit the [VHA Rehabilitation and Prosthetics Services site](http://vaww.rehab.va.gov/CS/index.asp) (<http://vaww.rehab.va.gov/CS/index.asp>).

### 7.3.2 Well-being Class Tracks

The WBP structure may vary from site to site but ideally will have nine tracks available to Veterans after they attend orientation. During orientation, Veterans will learn about the tracks and choose the class(es) that are most aligned with their PHP. [Whole Health for Skill Building Materials](https://www.va.gov/WHOLEHEALTHLIBRARY/courses/whole-health-skill-building.asp) (<https://www.va.gov/WHOLEHEALTHLIBRARY/courses/whole-health-skill-building.asp>) are housed in the

Whole Health Library. Classes are aligned with the eight areas of self-care outlined in the Circle of Health and PHP, with the addition of a track for health coaching.

The nine class tracks are:

- Power of the Mind
- Moving the Body
- Food & Drink
- Surroundings
- Family, Friends, Co-workers
- Recharge
- Personal Development
- Spirit & Soul
- Health Coaching

Planning considerations include:

- The Program offers a skill building starter class option for each area of self-care. This class can be utilized by the Veteran to explore self-care in a specific domain. [Materials for skill building starter classes](https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/WholeHealthSkillBuilding.aspx) (https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/WholeHealthSkillBuilding.aspx) are provided by the OPCC&CT and include a faculty guide, PowerPoint slide set, Veteran handout, and mindful awareness script.
- Whole Health coaches or other VA providers cross trained in Whole Health coaching skills are ideal candidates for leading the skill building classes. Additionally, utilizing providers from different disciplines such as nutrition, social work, psychology, or chaplain services to teach classes can help strengthen the connection across the WHS.
- Longer course offerings (e.g., six- to eight-week classes) can also be offered if there is Veteran interest and instructor availability. These classes need to be developed by the facility based on Veteran interest and instructor subject matter expertise. The OPCC&CT has developed curriculum guidance for these longer course offerings in the document, “Gearing Up for Whole Health: A Whole Health Self-Care Curriculum Development Guide.” This guide and additional resources can be found on the [Whole Health Education and Resources SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Implementation.aspx) (https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Implementation.aspx).
- Tracks can incorporate and build upon existing Physical Activity/Movement and Food & Nutrition programming and resources currently supported through Health Promotion and Disease Prevention (HPDP) Program Managers.
- Tracks can also incorporate and build upon educational content developed by local providers and experts (e.g. Registered Dietitians, Chaplains, Mental Health Providers, Physical Therapists, etc.).
- [#LiveWholeHealth blog series on VAntage Point](https://blogs.va.gov/VAntage/category/health/livewholehealth/) (https://blogs.va.gov/VAntage/category/health/livewholehealth/) is a self-care resource available for Veterans and staff and includes an experiential activity and additional resources.
- The nine [Healthy Living messages developed by NCP](https://www.prevention.va.gov/Healthy_Living/index.asp) (https://www.prevention.va.gov/Healthy\_Living/index.asp) in collaboration with other VHA program offices can also be a resource for Veterans participating in WBP tracks. Refer to these

### 7.3.3 Accessing Whole Health Coaching

Whole Health coaching is a service that empowers Veterans by focusing on their strengths so that they can make positive behavior changes and improve their health. These services extend beyond the roles or scope of the Whole Health partners and peers.

**Whole Health coaching helps Veterans stay motivated to make changes through education, value-based goal setting, action planning and coaching partnerships.** Whole Health coaches collaborate with Veterans in skilled, purposeful and results-oriented way to help them develop and sustain positive behavior changes. A Whole Health coach teaches and guides Veterans in mindful awareness practices to help them achieve their goals that are Specific, Measurable, Action-Oriented, Realistic, Timebound (commonly referred to as SMART goals) while focusing on the present and the future. Health coaching is not psychotherapy, and it is not solely education; it is health education and health promotion within a coaching context.

Barriers to access to health coach services should be removed, when possible. Models of health coaching that allow for direct scheduling with the Whole Health coach are encouraged, but direct referral from other service lines is also an appropriate referral model. Other pathways to directly engage with health coach services include marketing of the health coach programming and community outreach.

The core roles and responsibilities of Whole Health partners, Whole Health peers, the health coach and the certified health coach are unique but each support the engagement of the Veteran in well-being skills building programs. As illustrated in the figure below, each of these Whole Health team members play an important part providing education and acting as a liaison between Whole Health and MH-PCMH, being a subject matter expert (SME) for the WBP, completing the PHI, developing a PHP and SMART health goals, and coordinating the implementation of the Veteran's participation in the WBP.

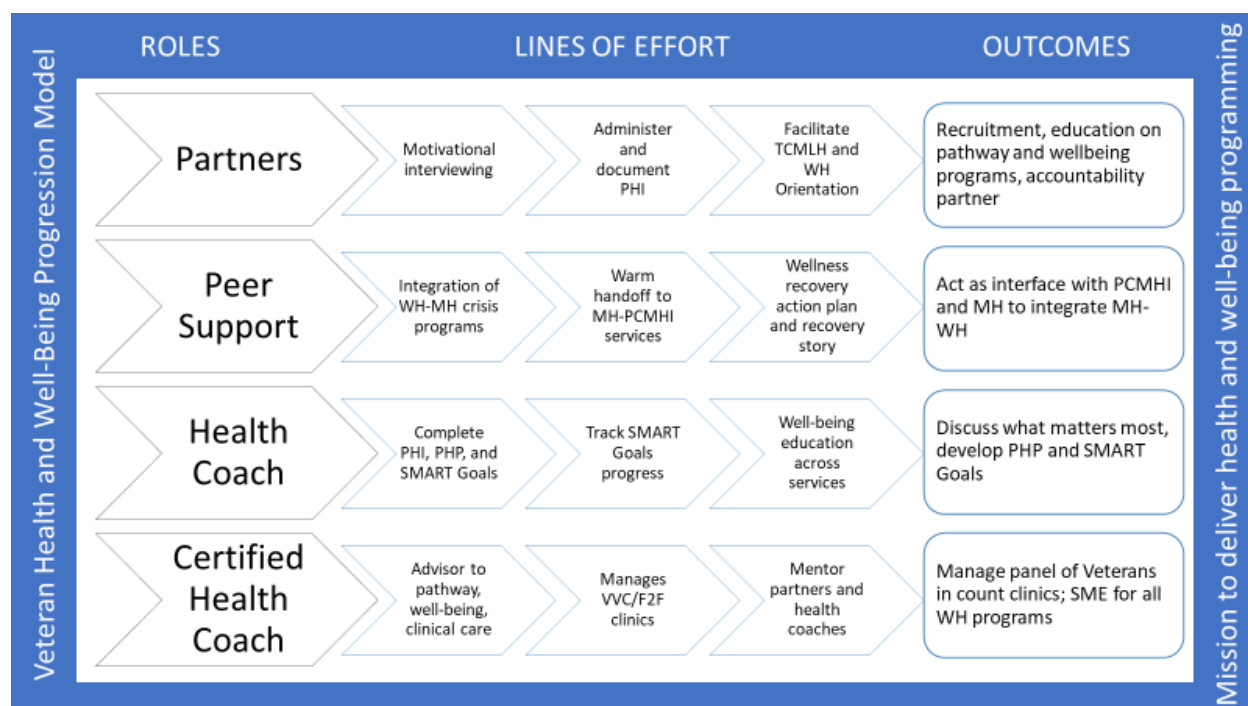


Figure 4: Health & Well-being Progression Model

## 7.4 Evaluating and Tracking Well-being Programs

### 7.4.1 Tracking Points of Entry

As a site develops and implements the mechanism(s) through which Veterans access its Well-being programming, it is important to track points of entry in these offerings. This will aid in evaluating their effectiveness and program utilization. Likewise, tracking points of entry can assist a site in coordinating Veteran care and the interface of WBPs with other WHS components, such as the Pathway and Whole Health Clinical Care, as well as Veteran self-enrollment.

Potential methods for tracking points of entry into WBPs include:

- Consults
- Orientations
- A spreadsheet entered manually by Well-being staff ("how did you hear about...?")
- Walk-in vs. referral clinics
- Whole Health Dashboard

Possible ways to access Well-being services/programming include:

- Develop an online portal with educational materials and media as an introduction to Well-being programs or for self-directed skills building
- Develop WBP introduction class with education and assessment leading to referral to subsequent skill building classes and offering CIH and other well-being approaches.
- Integrate SMART-goal guided selection and referral into Well-being programming

- Identify methods to reduce barriers to access to care, such as direct scheduling or RTC as appropriate into Well-being services rather than consult generation and management
- Develop community partnerships for referral to well-being programming or for self-directed engagement in well-being practices in the community
- Integrate WBPs with clear referral paths and network between WBPs, the Pathway and WHCC. One example of such a structure is shown in the figure below. The health coach (HC) is the liaison across the continuum of care.

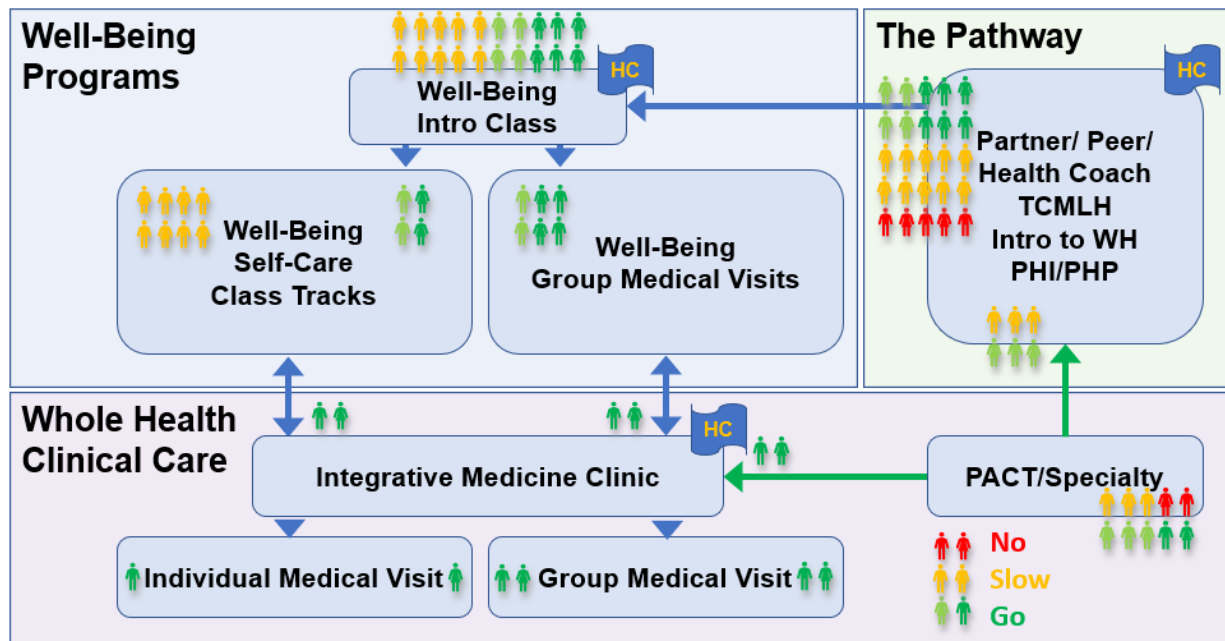


Figure 5: Example of Structure of WBP Integration within the Whole Health Model

**Figure 5 above demonstrates an example of a WBP referral process.** In this example, the majority of Veterans have their first contact with Whole Health in the Pathway, working with Whole Health partners, Whole Health peers, and health coaches (HC) to attend the Whole Health Orientation or TCMLH courses, completing a PHI and developing a PHP and SMART health goals. Veterans are then referred to the WBP introductory course relevant to their SMART goals. From the WBP introductory course, the Veteran is referred into either a WBP group, self-care skill building courses or a WBP group medical visit to work on self-management of pain or other health condition. When the needs of the Veteran exceed the benefits obtained from engagement in self-care, the Veteran is referred into the interdisciplinary integrative medicine clinic where a plan of clinical care is developed. Primary care and specialty services may refer less-complex cases directly to the Pathway. More complex cases may be referred directly for clinical care from the interdisciplinary team; the clinical care team evaluates and manages the more complex health conditions, referring the Veteran to the Pathway and WBP in a manner appropriate to their health concerns.

The WBP referral process shown in Figure 5 encourages the empowerment of Veterans to take charge of their own life and health by completing their PHI and PHP. They work to achieve their SMART goals by developing skills for self-care and management of their health condition. For the subset of Veterans for which self-care is not sufficient to manage their health condition, priority is given for their referral into

clinical services provided by the integrative medical clinic, as well as by PACT and specialty care services. This WBP referral design promotes Veteran engagement in self-care and self-management of health conditions to achieve well-being and conserves access to address health conditions requiring clinical care. Note: In some cases, the referral may go from the Pathway to Whole Health Clinical care, though that is not shown in this example.

#### 7.4.2 Metrics and Outcomes for Program Evaluation

Developing an evaluation plan for the WBP includes stakeholder involvement, program resources and design, selection of evaluation questions and measures, timing of measure capture, and plan for dissemination of the results of the evaluation. **Evaluation plans should include consideration of the following:**

- 1) Familiarization with the *Designation Framework* and self-assessment tool
- 2) Understanding of site-specific conceptualization and design of the WBP to be evaluated
- 3) Early stakeholder input in the development of the evaluation plan
- 4) Selection of tools to evaluate the effect pathway
- 5) Selection of tools to evaluate the process pathway

One key question in developing the WBP evaluation plan is to define the reasons for conducting the evaluation. The *Designation Framework* and self-assessment tool provide guidance on areas of program implementation and evaluation that must be met at each phase of implementation: Preparation, Fundamental, Developmental, and Full implementation. There may be other factors that contribute to evaluation goals, whether at the program level, site level, or VISN level. The evaluation must be customized to local needs, considering stakeholder input, organizational size and structure, population demographics, patient preferences and values, as well as programmatic design.

Involvement of stakeholders is key in the early stages of the development of the WBP evaluation plan in order to identify and articulate the specific interests of each stakeholder. Stakeholder interests may span patient satisfaction, program capacity and access to care, cost-benefits or cost-effectiveness, or other considerations. Stakeholders who should be involved in the development of an evaluation plan could be a beneficiary, or affected party, of the results of the evaluation, or an end user of the results of the evaluation. Stakeholders may also be Veteran participants, program managers or staff, clinical care stakeholders, governance or operations stakeholders, or researchers.

To evaluate the WBP outcomes, a structured evaluation may use an effect pathway to assess how the WBP is expected to change quality-of-life, behavior, environmental and general health outcomes (the effect on health). **Measures that might be appropriate to assess the effect pathway include:**

- Changes in PHI scores
- Achievement of PHP SMART goals
- Patient-centered outcomes
- Patient-reported outcome measures (PROMIS)
- Risk factors or surrogate biomarkers (e.g. BMI and HgA1c)
- Self-efficacy
- Veteran satisfaction
- Hospital admissions and readmissions



- V-Signals data

To evaluate the WBP implementation, a structured evaluation may use a process pathway to assess the WBP program as designed (the implementation process). Measures that might be appropriate to assess the process pathway include:

- Data extracted from the Whole Health Dashboard
- VERA ratings
- Utilization
- Program fidelity
- Appointment access times and waitlists
- Comprehensive use of services (both WH and across the HCS)
- Tracking RTC orders
- Fulfillment, cancellations and no-shows per Veteran for appointments across the Whole Health program, compared to the health care system

For more information about outcome measurement, refer to section [11. Evaluating Whole Health Implementation](#) of this *Guide*.

## 7.5 Integration of Well-being Programs with other Whole Health System Components

Impactful WBPs connect seamlessly with the other components of the WHS and involve the expertise of individuals across service lines. Part of the strength of a WBP is its emphasis on proactive and prevention-focused approaches. To that end, a WBP should optimally include some programmatic integration with disciplines/service lines that are heavily invested in a proactive and prevention-driven approach. This can include, but is not limited to, individuals from programs such as Health Promotion and Disease Prevention, Nutrition and Food Services, Recreational Therapy, and Chaplaincy. **Although labeled a “program,” WBPs should not be implemented as a separate entity siloed from other service lines.** Ideally it should involve individuals across service lines, creating alignment throughout clinical services so that the WBP truly reflects the WHS as a full system approach. This emphasis on an interprofessional approach, including stakeholders and employees from various disciplines and professions, reflects the spirit of WBPs in the ideal state - offering services to all Veterans despite diagnoses and disease states.

**Whole Health coaches are a valuable component of WBPs.** In addition to their contributions to Pathway programming, Whole Health coaches can provide much-needed support for Veterans who are going through the WBP, helping them to set up SMART goals to identify potential obstacles to achieving the goals, and to engage in proactive problem-solving. With the help of Whole Health coaches, Veterans will receive the support they need to practice and eventually master many of the skills they learn in the WBP. Whole Health coaches may also build upon the relationships they cultivated with Veterans in Pathway programming by encouraging those Veterans to engage in well-being activities and provide coaching to achieve their health goals; Whole Health partners and Whole Health peer facilitators (Whole Health peers) may also refer Veterans into WBPs to receive a more intensive Whole Health experience. This puts Whole Health coaches, Whole Health peers and Whole Health partners in a unique position in



which they can be very knowledgeable about the current state of all the components of the WHS at their facilities, due to the nature of their work.

It is crucial that the interprofessional team members who are involved in the WBP regularly communicate and coordinate with those team members who are responsible for Pathway and Whole Health Clinical Care. The core components of the WHS (Pathway, WBP and WHCC) are distinct entities but cannot operate in isolation from each other. A sound WBP evaluation should include an assessment of how well the WBP is advertised and integrated with Pathway and WHCC. The goal of the WHS is to provide Veterans with a comprehensive Whole Health experience that minimizes barriers to access. Working in departmental or programmatic silos, lack of consistent communication across programs and service lines, as well as territorial concerns, are threats to a healthy WHS. In order to mitigate these risks, individuals involved in the WBP should routinely assess their implementation progress via the *Designation Framework* and reflect on their operational strengths and opportunities regarding their level of collaboration and integration with other WHS components.

## 7.6 The Personal Health Plan (PHP) within the Well-being Program

The PHP is an essential aspect of the Veteran's journey through the WBP. There are many different ways a Veteran can use the PHP to explore their mission, aspiration and purpose (MAP), create goals, and determine which WBP classes and tracks would best support their MAP. During the Veteran's experiences in the WBP, other shared goals (and related SMART goals) may be established with well-being and CIH providers, thereby expanding the PHP.

If a Veteran attends the WBP with a written PHP already started, the Veteran would ideally use the PHP to help align program use with his/her MAP and identified goals/priorities. When a Veteran attends a WBP without a PHP but with interest in creating one, the Veteran should be provided with an overview of the PHP and Well-being class options with the assistance of a Whole Health coach. The Veteran can also elect to engage with a Whole Health peer, Whole Health partner, other facilitator or the Pathway programming to begin the PHP process.

Additional aspects of personal health planning in a WBP can include the following:

- Providing forums to discuss what matters most to Veterans (MAP exploration)
- Providing education and information regarding CIH and well-being approaches and how they impact health and well-being
- Conducting CIH approach-specific assessments
- Providing education through VA and community CIH and well-being resources
- Offering engagement with Whole Health coach, Whole Health partner, *TCMLH*, Pathway, or Whole Health Clinical Care programs
- Offering the Veteran the opportunity to connect with other Whole Health facility programming in support of MAP (e.g., Healthy Living, Food and Nutrition, MOVE!, etc.)
- Engage in the Class Tracks to support PHP goals

### 7.6.1 Referencing the PHP as a Well-being Provider or Coach

The PHP is also an essential tool for Well-being providers to coordinate care within the WBP at a facility and in the community. A Well-being provider or coach can use the PHP to plan engagement in CIH and other well-being resources, class tracks and other programming that supports the Veteran's MAP. For

instance, if after attending the WBP orientation the Veteran is interested in multiple offerings (such as MOVE!, Tai Chi or yoga), the provider can help the Veteran to determine which opportunity might best support the Veteran's MAP. Likewise, Well-being providers and coaches can use the PHP and MAP to prioritize modalities when access to programming is limited due to Veteran demand and/or available resources.

The PHP can also be used as a reference to keep track of a Veteran's goals for care. As Veterans accomplish their goals, the PHP can be updated as needed to incorporate progress and new goals that may be set by the Veteran. Ultimately, providers in the WBP will continue to reference Veterans' MAPs, PHIs, and PHPs throughout the WBP offerings, which will allow Veterans to partner with their providers to coordinate Veteran-centric care.

## Resources

[Well-being Domain SharePoint Document Library](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WellBeing_Domain/Forms/AllItems.aspx) (https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WellBeing\_Domain/Forms/AllItems.aspx).

[IHCC section of the Whole Health Hub](https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC) (https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC)

[Whole Health for Skill Building Materials](https://www.va.gov/WHOLEHEALTHLIBRARY/courses/whole-health-skill-building.asp) (https://www.va.gov/WHOLEHEALTHLIBRARY/courses/whole-health-skill-building.asp)

[Materials for skill building starter classes](https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/WholeHealthSkillBuilding.aspx)

(https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Whole Health Skill Building.aspx)

OPCC&CT curriculum guidance, "Gearing Up for Whole Health: A Whole Health Self-Care Curriculum Development Guide" on the [Whole Health Education and Resources SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Implementation.aspx) (https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Implementation.aspx).

[#LiveWholeHealth blog series on VAntage Point](https://blogs.va.gov/VAntage/category/health/livewholehealth/)

(https://blogs.va.gov/VAntage/category/health/livewholehealth/) is a self-care resource available for Veterans and staff and includes an experiential activity and additional resources

[IHCC FAQ- Power Apps](https://apps.gov.powerapps.us/play/4b106e97-2c02-4484-a0cb-dc0bfe8695fd?tenantId=e95f1b23-abaf-45ee-821d-b7ab251ab3bf) (https://apps.gov.powerapps.us/play/4b106e97-2c02-4484-a0cb-dc0bfe8695fd?tenantId=e95f1b23-abaf-45ee-821d-b7ab251ab3bf)

[Other Well-being Related Toolkits/Project Overviews](https://dvagov.sharepoint.com/sites/VHAOPCC/Innovations/ToolkitsProjectOverviews/Forms/AllItems.aspx?viewid=94be29e6%2D14ac%2D4442%2Db341%2D74b659991369&id=%2Fsites%2FVHAOPCC%2FInnovations%2FToolkitsProjectOverviews)

(https://dvagov.sharepoint.com/sites/VHAOPCC/Innovations/ToolkitsProjectOverviews/Forms/AllItems.aspx?viewid=94be29e6%2D14ac%2D4442%2Db341%2D74b659991369&id=%2Fsites%2FVHAOPCC%2FInnovations%2FToolkitsProjectOverviews). This is collection of previous OPCC&CT innovations grant summaries, including programming ideas that are related to Whole Health and/or Veteran well-being.

## 8. Whole Health Clinical Domain

### 8.1 Introduction

**Whole Health Clinical Care (WHCC) is not a new project or program, but rather represents a cultural transformation in our collective clinical practice which requires tactics that differ from standard program implementation efforts.** Because this requires a change to existing practices instead of building a new program or role, this can seem daunting, difficult, and sometimes require a longer timeframe for implementation. The guidance, information, and recommendations contained in this *Guide* are based on progress made by clinicians and clinical team members who have paved the way as early adopters and champions of WHCC over the past several years. Since **WHCC involves the transformation of the approach to clinical care**, the starting place will vary depending on the site and the team and will be personalized based on your discipline and the Veteran population you care for in your practice. This *Guide* will walk you through the steps and lessons learned that have helped others on their journey to use Whole Health in the clinical care setting.

**Bottom Line Up Front: Successful Whole Health Clinical Care interactions create an experience in which Veterans can say yes to the following vSignals question, “My healthcare team included what matters most to me in my plans for what to do next to manage my health and well-being.”**

When you are considering whether or not you are using a Whole Health approach in your practice, the following basic questions can help you get started or continue your journey. Changing the conversation and connecting with a Veteran’s MAP is step number one.

*Table 7: Key Questions for Veterans and Clinicians*

Example Questions to Ask Your Veteran	Questions to Ask Yourself
<i>My healthcare team included what matters most to me in my plans for what to do next to manage my health and well-being.</i>	I know what matters most to this Veteran in their life.
What is most important to you in your life right now?	We set shared goals that connect directly to what matters most to them in their lives.
Tell me something you can do in your life today that will help you move towards that purpose?	I offer as wide a range of conventional and CIH resources as appropriate and possible to help the Veteran reach their goals.
	I am aware of the importance of self-care for my own health and well-being in addition to that of my patients.

This may be happening in your visits already, and if it is already happening, congratulations! If it isn’t, or if you want to take Whole Health in your clinical practice or at your facility to the “next level,” then please read on. This chapter will offer you an overview of what we’ve learned from the efforts to date, so that you (either as an individual or an organization) can develop an implementation plan informed by the successes of others and that works best for you.

If your main goal is to advance at an organizational level along the *Designation Framework* toward full implementation of WHCC, we strongly suggest leveraging your FIT Consultant to help determine the best way to start (or continue) implementing Whole Health in clinical settings. A phased implementation approach is recommended, as outlined in the *Designation Framework*, in addition to using change management principles. For example, establishing appropriate governance, building awareness and desire for the change, and engaging leadership and key stakeholders prior to formal implementation are all critical pieces to large-system transformations.

## Journey to Whole Health Clinical Care

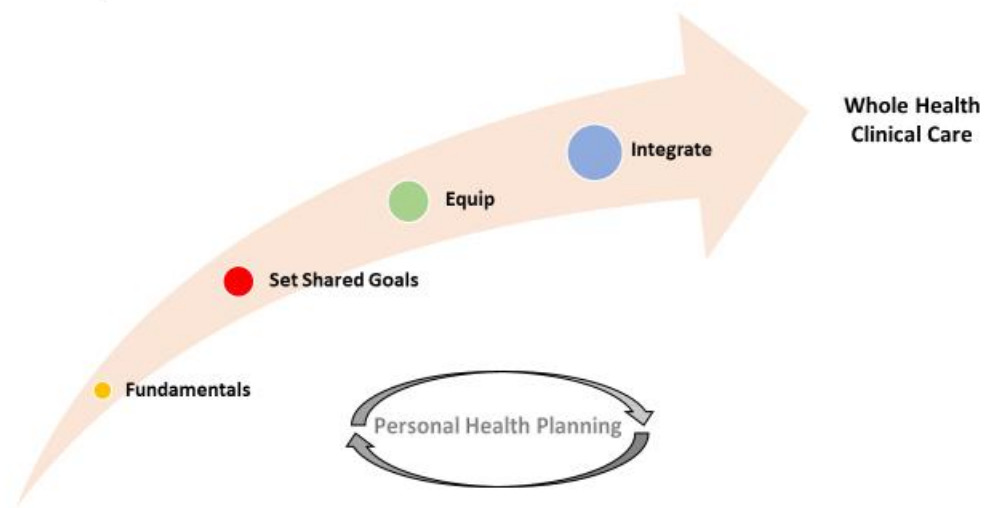


Figure 6: Journey to Transforming Clinical Care

Fully designated Whole Health Clinical Care is achieved through the integration of each of the steps shown in the figure above. These steps include 1) the Fundamentals, 2) Set Shared Goals, 3) Equip, and 4) Integrate. As shown by the arrows, Veteran empowerment is increasingly supported as each step is implemented, and personal health planning is a cyclical and ongoing process underpinning all aspects of WHCC. **These steps are conducted seamlessly to deliver excellent clinical care that results in the Veteran feeling empowered and equipped to live their life to the fullest in support of what matters most to them in their lives (MAP).** For each step outlined in this figure, there is a corresponding section in this chapter.

WHCC develops and links shared goals for health and well-being (and associated interventions) directly to what matters most to the Veteran in their life (their MAP). It collaboratively helps Veterans develop or refine their Personal Health Plan (PHP) and uses this plan to guide their care.

To equip Veterans in doing so, WHCC connects them with resources such as Pathway or Well-being programs, complementary and integrative health (CIH) approaches, Whole Health coaching, and the community to not only treat illness, but to also support health and well-being. WHCC can be done at individual, team, program and system levels, and does not necessarily require additional resources to

achieve the heart of this work: **connecting assessment and treatment to the MAP in a meaningful manner.**

**You may be surprised to learn that individuals and teams can integrate Whole Health into clinical practice without additional resources. A sound strategy to address concerns about clinician time is to customize your approach and start from a place of strength. Individuals and teams will be at different places along this journey at any given time. It's important to discover and honor the talents and skills of clinicians before starting on this transformation. Often you may discover that a person or team's practice already includes elements of Whole Health Clinical Care. Meet clinicians where they are, connect Whole Health with the work they are already doing or are required to do, and partner with them to establish goals to help them move towards a fully transformed Whole Health Clinical Care approach. This is consistent with how we interact with our Veterans in setting shared goals!**

It is useful to connect with the “why” of Whole Health Clinical Care. We strongly encourage the reader to review the document “[Why WH Clinical Care? 6 Questions Answered](https://dvagov.sharepoint.com/:w:/s/VHAOPCC/WH-Implementation/Ean9ATwJfgRAIY9owa4d5wYBwYfkFjmi-rTC1mxiu6539A?e=T2wuK7)” (<https://dvagov.sharepoint.com/:w:/s/VHAOPCC/WH-Implementation/Ean9ATwJfgRAIY9owa4d5wYBwYfkFjmi-rTC1mxiu6539A?e=T2wuK7>). For us to be successful in creating and sustaining change, we need to apply change management methodologies. This is covered briefly in later sections.

In the following sections, we will take a closer look at what characterizes the WHCC approach and its implementation, which represents an evolution from the current state to a more holistic state. We have also included a series of “Myths and Tips” where we address potential preconceived notions about WHCC. While there are many routes to reaching WHCC, there are some critical factors that are associated with success. We are therefore providing a summary of lessons learned from the past three years’ experience with the Whole Health Flagship Sites and prior experience from Whole Health Design Sites in section [8.7 Implementation Lessons Learned](#).

While the *Designation Framework* is organized by phase, this chapter is outlined by topic area to minimize redundancy and duplication (given that topics such as connecting to MAP occur in multiple phases of the *Designation Framework*). Implementation of WHCC occurs across a continuum, as discussed at the beginning of this chapter. For your reference, the phases of WHCC implementation are outlined in the [Designation Framework for Whole Health Implementation](https://dvagov.sharepoint.com/:w:/s/VHAOPCC/EUdWEp9OfqtGt3wL4-VZ3mIBIRzn6chrEYAyqfc7ffTdyw?e=flmsq5) (<https://dvagov.sharepoint.com/:w:/s/VHAOPCC/EUdWEp9OfqtGt3wL4-VZ3mIBIRzn6chrEYAyqfc7ffTdyw?e=flmsq5>).

Finally, let’s explore “wording.” When concepts such as Mission, Aspiration, Purpose are referred to, please know that this is for ease of reference. If you have a style of introducing Whole Health that includes slightly different words but that represents the same concepts, that is ok! Whole Health is not locked into a specific set of terms or tools; it is the spirit and meaning behind them that is the true transformation.

An important piece of implementation is the evaluation of your efforts to inform process improvement and show success in transformation. This chapter will discuss some strategies for tracking WHCC activities as well as evaluating outcomes. Keep in mind, it’s a good idea to set some of these processes up early in implementation so you can use them to monitor ongoing progress. Connecting a measurable

outcome, whether qualitative or quantitative, to your strategic goals can set you up for success throughout this journey.

Now, let's take a deeper dive into the journey to transforming to Whole Health Clinical Care.

## 8.2 Fundamentals of Whole Health Clinical Care

In a fully designated Whole Health System, VHA clinicians and teams actively partner with Veterans to align health goals and treatments with what matters most to the individual, and support and/or equip them with the resources needed to achieve those goals.

**But how would a clinician know if they are practicing in a way that is consistent with Whole Health?**

As noted above, the intention of using a Whole Health approach in clinical care is to ensure that the Veteran feels supported and equipped to live their life to the fullest in support of what matters most to them in their lives (MAP). If Veterans are leaving their clinical encounter with this perception, one can argue that Whole Health is being provided.

That said, many clinicians and teams have asked, “But HOW do you get to that point?” The following provides a summary of actions that can be taken to increase the likelihood that the above aim is achieved. This summary was informed by the responses of providers practicing in the field, along with key principles associated with patient-centered care. It may be helpful for clinicians and team members to examine which of these they are already practicing, and which of these they might like to include in their practice to see benefits for Veterans, teams, and themselves.

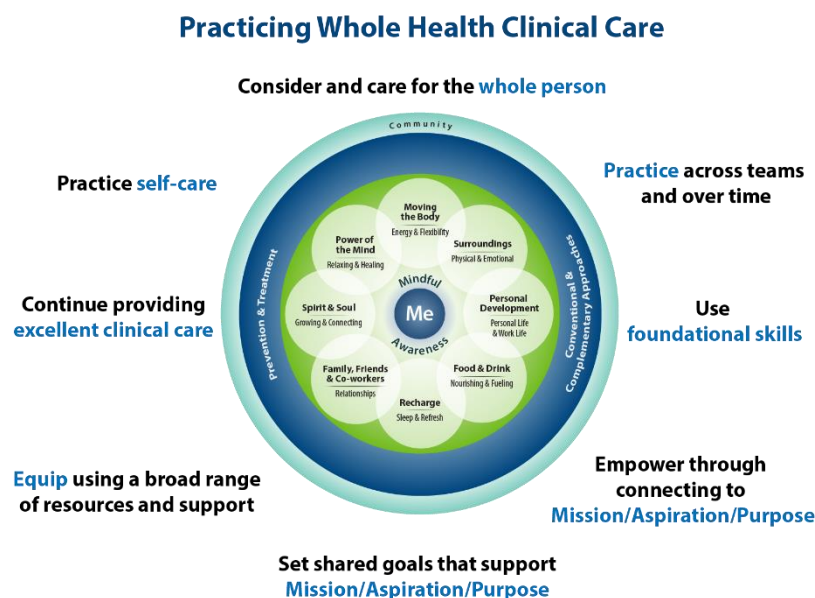


Figure 7: Characteristics of the Practice of Whole Health Clinical Care

**The essential characteristics of WHCC are shown surrounding the Circle of Health in the figure above.** When clinicians and teams explore these characteristics, they often find that they are already practicing in some ways that are consistent with this list. Next steps can then be defined by identifying areas for additional learning, skill building and/or enhancement. These characteristics include:

- **Whole-person Care:** WHCC includes the consideration of, and commitment to, care of the whole person: physical, mental, emotional, spiritual, and social. The Circle of Health can provide a basic guide and discussion tool for clinical team members and Veterans to ensure they are addressing the components of health and well-being
- **Practice Across Teams and Time:** WHCC is not dependent on any one individual or role, nor does it require that a “checklist” of activities be conducted at every visit. WHCC is patient-centered practice that is interwoven across all clinical programs, professions and activities. Longitudinally, the clinical experience a Veteran has with their teams incorporates all these elements, albeit potentially at different times across various programs. Additionally, well-functioning teams are best equipped to provide WHCC, thus trainings or programs that enhance teamwork can be instrumental for implementation as well
- **Foundational Skills:** Practicing WHCC is made possible through effective patient-centered care that includes communication, strong relationships, motivational interviewing, diversity and cultural awareness, and therapeutic presence. This can sometimes require further education and practice. There are many offerings in VHA that help to build these skills. Examples of other programs and resources relevant to Whole Health include:
  - **Healthy Living Messages, TEACH, Motivational Interviewing**, and more from the [VHA National Center for Health Promotion and Disease Prevention](https://www.prevention.va.gov/) (<https://www.prevention.va.gov/>)
  - **Goals of Care Conversation training** from the [National Center for Ethics in Healthcare](https://www.ethics.va.gov/goalsofcaretraining/Practitioner.asp) (<https://www.ethics.va.gov/goalsofcaretraining/Practitioner.asp>)
  - **Own the Moment training** from the [VHA Veterans Experience Office \(VEO\)](https://dvagov.sharepoint.com/sites/VACOVEO) (<https://dvagov.sharepoint.com/sites/VACOVEO>)
  - **VA Voices** (<https://dvagov.sharepoint.com/sites/VAVoices911/SitePages/Home1.1.aspx>)
- **Empower Through Connecting with MAP:** Connecting with and building care on a person’s deepest values, priorities or purpose is essential to practicing WHCC. This is the “game changer” of WHCC and is a key factor that differentiates WHCC from practice as usual. Given its central relevance, the next section of this guide is devoted to these topics. Again, each individual clinician will find their own way or method of asking questions to understand the Veteran’s MAP. Not only is that encouraged, it is the hope. This connection creates a personalized experience that not only benefits the Veteran, but also contributes to provider resiliency while re-establishing the human connection in healthcare
- **Set Shared Goals that Support the MAP:** The clinician partners with the Veteran to set goals that match and support what is most important to the Veteran, and that are also informed by the clinical expertise of the clinician/team. When treatment, self-management, and self-care are aligned with what matters most to the individual, the plan is truly personalized
- **Equip Using a Broad Range of Resources:** Once collaboratively-determined shared goals are established, Veterans are connected with a broad range of resources and support in service of those goals. This extends beyond standard clinical referrals to also include resources available via the Pathway, Well-being Program, as well as CIH, Whole Health coaching, disease management programs/courses, community resources, education opportunities, tools etc. Importantly, this also includes resources that support self-care



- **Continue Providing Excellent Clinical Care:** VHA clinicians strive to provide excellent clinical care for our nation’s Veterans. This clearly remains critical. Practicing WHCC continues that mission and connects this work (clinical assessment, diagnostics, treatments, referrals and documentation) with what matters most to the individual. WHCC does not “replace” any existing programs either. Rather, it can be thought of as an essence of or approach to care that is interwoven throughout all programs. As clinicians gain a deeper understanding of the Whole Health approach to care, they will be able to connect each of the components of health and well-being, and associated behavioral and lifestyle choices, to disease progression or mitigation. For example, rest and recharge could reveal a lack of sleep which can lead to worsening chronic pain. Similarly, stressors in the family, friends, and co-workers area can contribute to chronic hypertension. These connections can help inform shared goal setting and are very important in personal health planning. Every component has a meaningful influence on illness and disease and overall well-being
- **Practice Self-Care:** Clinicians often prioritize their own self-care at the bottom of their “to-do” list, and yet we know it is essential to improving resiliency, joy in the work they do, and healthcare burnout. Clinicians should experience Whole Health for themselves and incorporate self-care practices into their lives that meet their mission and purpose. By practicing self-care, it becomes easier to encourage and educate Veterans and other team members in the Whole Health approach to care. Please refer to section 9. [Employee Whole Health Domain](#) of this *Guide* for additional resources to support employees as they develop their own self-care practices

**The presence of these characteristics in an individual’s or a team’s practice over time and across the organization may reflect the transformation of clinical culture, but it may be most evident in how a Veteran would describe their experience. Does the Veteran think their health care team cares about them and what matters to them in their lives? Does the Veteran feel supported to take a step forward in improving their health and well-being? We are striving to provide a health care experience that would result in “Yes” to both such questions a majority of the time.**

Of note, aiding clinicians and clinical teams to use the WHCC approach in their practice may require additional education and skill building. For many teams, this may be an evolution of their existing skills or practices. It can be helpful to use the map in Figure 6, shared at the beginning of this chapter, to understand where individuals or teams are in terms of this evolution. Some teams may already be using their fundamental communication skills and are ready for introducing the essential MAP questions. Others may need refreshers in their motivational interviewing skills. Others may not need to make any changes at all!

**The following are the core competencies used when providing Whole Health education** that can help shape the integration of Whole Health into clinical practice:

1. Help Veterans explore their own health and well-being and co-create a PHP, incorporating their values (MAP)
2. Work effectively as part of an interprofessional team
3. Demonstrate advanced skills in communication, empathy, and facilitation of behavior change in Veterans and families
4. Integrate CIH (appropriate professionals and approaches, evidence- based)



## 5. Care of the caregiver (Whole Health for clinician/staff self-care)

For an overview OPCC&CT educational courses focused on WHCC, please explore the [OPCC&CT Education SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Home.aspx)

(<https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Home.aspx>). Prior to conducting such training, however, it is strongly recommended that exploration and cultivation of people's awareness and buy-in be conducted beforehand. Along these lines, it is also helpful for clinical teams to experience Whole Health for themselves, which can be done through various local and national-level forums, communities of practice, and courses. Please refer to section 9. [Employee Whole Health Domain](#) in this *Guide* for more information about offering such opportunities to staff.



### *Myths and Tips #1: "I'm already doing Whole Health Clinical Care"*

*Whole Health Clinical Care is definitely not a yes/no answer. It is entirely possible that you are doing Whole Health Clinical Care, and it is highly likely that many of us are doing elements of this type of care. This is an evolution in which we are trying to deliver a more personalized approach that is rooted in a Veteran's purpose for health. It's important to validate what is going well and work towards a future state that includes the Whole Health System, not just the clinical visit. Highlighting the pieces of the model that occur outside of the visit, such as Pathway, Well-being Programs, and Community Partnerships, can help clinicians see how Whole Health is a systems approach that does not rest solely on their shoulders. Be sure to use the ADKAR change management model in support of Whole Health implementation, as initial resistance is quite common in the early stages of awareness. Offer clinicians the experience of Whole Health so they can become more aware of the change we are trying to make.*

## 8.3 Setting Shared Goals (aka "Map to the MAP")



### *Myths and Tips #2: "MAP opens Pandora's box."*

*Providers who ask this question typically hear aspirational answers the majority of the time. If asking about MAP uncovers suffering instead, it will reveal an opportunity that might otherwise have been missed. This type of emotion, pain, or suffering is often linked to physical or mental manifestations of disease and is necessary to know to develop effective treatment plans. Use this as an opportunity to connect the Veteran to the right resources to further explore these feelings either in that moment or in follow up, depending on urgency.*

**As noted earlier, the process of "mapping to the MAP" is the real game changer.** Once teams have had time to practice, they can apply their fundamental skills with Veterans in further work around their MAP. It is a good idea to give teams time to learn how to ask MAP questions in their own way to honor the unique relationship between a provider and a Veteran, and to promote authenticity and therapeutic presence. Clinical teams can learn about a Veteran's MAP through a variety of ways, including understanding the work that the Veteran has done in the Pathway groups, through asking "what matters most to you in your life?" or "what do you want your health for?", or through the use of tools such as the Personal Health Inventory (PHI). Connecting shared goals with the Veteran's life values or

priorities helps ensure that goals are meaningful both to the Veteran and to the clinical care team, and ideally enhances Veteran engagement and success.

Some sites may opt to “start small to win big” when it comes to connecting with MAP. A reasonable place for almost any site or program to begin transforming the delivery of their clinical care is to begin by having clinicians and staff “change the conversation.” This means starting the conversation with the Veteran as an individual as opposed to their disease or problem (e.g., Veterans can be given an opportunity to reflect on the key questions and share their MAP with their clinician). Sites and individual clinicians can tailor how these questions are asked (e.g., the order or covering one per visit). The approach should be the one that most naturally integrates with existing practices or flow.

**Sample questions that could be asked by the clinician include:**

- What is most important to you in your life right now?
- Tell me something you can do in your life today that will help you move toward that?
- What REALLY matters to you in your life?
- What do you want to be healthy for?
- What brings you a sense of joy and happiness?
- What is your vision of your best possible health?

**One Veteran’s Answer to “What do you want to be healthy for”: “I intend to stay crime and alcohol/drug-free by continuing with my personal growth; pursuing my education; and helping others through my future career.”**

Some clinicians worry that asking these questions will require substantially more time. While it may take some time to practice and find a rhythm, ultimately knowing the answers to these questions may save time. Connecting with what matters most to someone can be as simple as it sounds and does not require an overhaul of clinical processes or procedures to accomplish.

If you would like to learn more ways for engaging in meaningful inquiry, changing the conversation, addressing perceived barriers and answering clinicians’ frequently-asked-questions, refer to the [Passport to Whole Health](#)

(<https://dvagov.sharepoint.com/sites/VHAOPCC/Shared%20Documents/Forms/AllItems.aspx?id=/sites/VHAOPCC/Shared%20Documents/Communications/Education%20Print%20Products/Passport%2009-2020%20for%20printing%20only.pdf&parent=/sites/VHAOPCC/Shared%20Documents/Communications/Education%20Print%20Products>). Also, such content is covered in the “Whole Health in Your Practice” and other OPCC&CT Whole Health clinical courses.

While you know your program and practice best, OPCC&CT FIT Consultants can aid you by providing examples of how other sites/programs have been successful with eliciting and connecting to the MAP. Ultimately, meaningful questions help clinical teams understand the individuals they are caring for. The answers they uncover directly impact physical and mental health conditions, and the information teams glean can help create more robust treatment plans.

**Whole Health in clinical care aims to ensure that Veterans receive health care that connects with what matters most to them in their lives (MAP, priorities, values) and that their team provides access to resources that will equip them in reaching their best level of health and**

well-being. If we do not connect our efforts to equip Veterans with resources, referrals, tools, skill-building and education to their MAP, we are missing the critical transformative step in clinical care.



*Tip #3: “While encouraged, the Personal Health Inventory (PHI) is not ‘required’ for use by OPCC&CT clinical teams.”*

*The PHI is a useful self-reflection tools for Veterans and is used in many facilities, groups, and programs. It can also aid clinical teams in explaining Whole Health, connecting with a Veteran and their MAP, and exploring Veteran priorities. At first, some teams may be drawn to using the PHI as a training tool to help themselves become practiced at integrating Whole Health-oriented discussion into their standard flow of care. Over time, many clinicians and teams become comfortable having these conversations without the aid of a form, and instead may elect (for example) to keep a poster of the Circle of Health up in their exam room. **It is really up to you!***

Veterans become engaged in their care and decision-making when clinical teams are co-creating goals with them. When these conversations are connected to the Veteran’s MAP and self-care goals, we call it “shared goal setting,” and it is similar in some ways to shared decision making. With shared goal setting, we are not focusing solely on disease. We are purposefully connecting with MAP and addressing the components of health and well-being while providing clinical care. Our emphasis is on what matters most to the Veteran. We have found that when we focus on what matters most, many of the behavior and lifestyle choices contributing to diseases and conditions such as diabetes, chronic pain, heart disease, and depression, to name a few, can be better addressed and improved.

**In the context of Whole Health, one of the most important roles of the clinician is to work with the Veteran to understand their current social determinants of health** to set realistic goals for achieving greater well-being, and to support and collaborate toward achievement of those goals (refer to section [10.9 Social Determinants of Health](#) of this *Guide* for further information). In this way, the Veteran and the clinician have entered into an agreement, a partnership built on establishing goals and supporting the Veteran in progress toward those goals. This is what is meant by the “shared commitment to goal achievement,” as illustrated in the figure below. The area where the separate circles overlap represents the shared goals between the Veteran and their clinician (or clinical team) that drive care in the Whole Health model.



Figure 8: Shared Goals

By forging this shared commitment, the Veteran and the clinician make connections between what brings meaning to the Veteran's life, where s/he may have priorities for self-care, and the goals that, when achieved, will lead to a Veteran's optimal health and well-being. The clinician partners with the Veteran to set goals that match and support what is most important to the Veteran, and that are also informed by the clinical expertise of the clinician/team. You are the expert in your field and should share this important knowledge, and Veterans are the expert in their lives and should also share their motivation and goals for well-being. This engagement approach is an important aspect of Whole Health. By setting their own goals, the Veteran is more likely to commit to changes in health behavior where they may be needed.

**Goals based on other factors, such as another person's desires or priorities, and that are not grounded in the Veteran's own life values, are far less likely to be achieved or sustained over time.**

To learn more about setting shared goals and an example scenario of shared goal setting, please see the [Passport to Whole Health](https://dvagov.sharepoint.com/sites/VHAOPCC/Shared%20Documents/Forms/AllItems.aspx?id=/sites/VHAOPCC/Shared%20Documents/Communications/Education%20Print%20Products/Passport%2009-2020%20for%20printing%20only.pdf&parent=/sites/VHAOPCC/Shared%20Documents/Communications/Education%20Print%20Products) (<https://dvagov.sharepoint.com/sites/VHAOPCC/Shared%20Documents/Forms/AllItems.aspx?id=/sites/VHAOPCC/Shared%20Documents/Communications/Education%20Print%20Products/Passport%2009-2020%20for%20printing%20only.pdf&parent=/sites/VHAOPCC/Shared%20Documents/Communications/Education%20Print%20Products>).

**Here are few tips for developing shared goals:**

- Always make sure a goal connects back to a person's MAP and self-care goals or priorities, and that the connection is clear and understood by both parties. The best way to ensure this is happening is to ask the Veteran!
- As a health care team member, you should both share your perspectives and honor those of the person you are supporting. Be sure to communicate with them about why you have the goals you do
- Documentation will help make it clear to all team members what someone's MAP is, and how their goals help them move toward it
- Encourage Veterans to reflect upon and share their MAP and self-care goals, including those Veterans that tend to defer to your expertise and opinions

Consider the time this process takes up front to be an investment that will likely lead to greater buy-in and commitment to follow through on the plan you co-create, and that it will pay off in the long (and short) run.

Many existing VA initiatives share a focus on empowering the Veteran for self-management and shared decision making, and Whole Health builds on these initiatives. The Planned Care Model, Self-Management Support, and Veteran-Centered Health Education programs all work to support collaborative goal setting between clinicians and Veterans. These approaches have been promoted over the past several years through Primary Care/National Center for Health Promotion and Disease Prevention (NCP)-sponsored educational programs and provide an important foundation for the spread of WHCC. For example, the TEACH for Success and Motivational Interviewing courses have been completed by over 35,000 PACT clinicians since 2010.



#### Myth #4: "I don't have time for this."

*It seems there is never enough time to do everything we are asked to do or want to do. Taking a Whole Health approach can not only help the clinical team address some of the requirements they face, but also deliver the kind of care they went into health care to provide. And, any new skill takes time to master. When clinical teams have become aware of Whole Health and express a desire to use this approach in their practice (change management can help with this!), it is wise to start small and allow any changes to become second nature before moving on to anything else. Discuss together how this approach aligns with the "have-to-do's" on their plates, and where might be a reasonable place to start. Whenever possible, work with clinicians and teams to see what they are already doing that is consistent with a Whole Health approach. **Depending on resources, try to give clinicians resources to ease their burden (access to Whole Health partners, Whole Health coaches, well-being resources, community partners, employee well-being resources, etc.).** While each clinician, team and program will have their own way of integrating Whole Health into their practice, it can be helpful to highlight best practices from similar professionals across VHA to inform their decisions about the right place to start (or how to continue). It is also good to discuss the items that tend to take up much of their time. These issues often relate to communication, education, and motivation problems. Based upon early outcome data from the 18 Flagship Sites implementing the Whole Health System of care, practicing Whole Health can often help decrease the use of hospital resources over time, which may in turn save the clinicians time and enhance access.*

## 8.4 Equip

Once shared goals are set, the clinical team then equips the Veteran with resources, tools, services, and skill-building opportunities, and engages and/or consults with other healthcare team members who can help the Veteran pursue those goals.

Through the Whole Health System, Veterans have the chance to work with clinicians, Whole Health coaches, CIH instructors, and community partners as available to achieve their shared goals. Veterans may already be working with some of those team members in support of their health and well-being goals before seeing their clinical team. If they are not, however, it is appropriate for the clinical team to discuss how such resources may further support the Veteran's needs or goals, and to help to connect them with those resources.



#### Myth # 5: I don't have any Whole Health resources to do this work, so I can't do Whole Health

*Whole Health is an approach to care, and therefore, can be done even if you have minimal additional Whole Health Staff or resources. Whole Health Clinical Care involves connecting with a Veteran's MAP to better understand what matters most and set shared goals for success. Clinicians and teams can learn these skills over time and incorporate them into their existing workflows. As you add more Whole Health resources over time, such as Whole Health partners, coaches, and CIH approaches, you can include them in your personal health planning with Veterans. Remember, starting with individual change is critical to success. Changing the conversation and connecting with a Veteran's MAP is step number one.*

*Existing resources can be used in support of a Veteran's shared goals, as can other aspects of the Whole Health System (i.e., Pathway and Well-being Programs). For example:*

*Shared Medical Appointments (SMAs), disease-based self-management programs, and treatment programs can all be used.*

*Veterans can be offered the opportunity to participate in an Introduction to Whole Health course to learn more about MAP and components of their Personal Health Plan.*

*Whole Health coaches can help Veterans explore life and self-care goals in detail.*

*CIH approaches may offer useful skill building and health benefits to complement clinical care plans.*

*To assist clinicians and teams, many facilities catalog the available resources through print or digital means. These resources are used to support achievement of shared goals, which are developed based on the Veteran's MAP.*

#### 8.4.1 Personal Health Plan Documentation

To aid in coordinating such activities across the Whole Health System, and in support of Veteran ownership, the Personal Health Plan (PHP) offers the opportunity for both Veterans and their team members to document progress in the electronic health record (EHR). The PHP is a dynamic template that serves as an individualized plan for every Veteran and is included as a national template in CPRS. **The PHP is not “owned” by the clinical team. Instead, it is owned by the Veteran, and the Veteran can start or complete their PHP independently, or in partnership with various members of their health team.** There is no “one” way to complete or begin the PHP. For example, it can be started by the Veteran through the *Whole Health App* or online via a fillable .pdf file. The PHP can be introduced via Whole Health Pathway courses, during Whole Health coaching visits, or during the Whole Health Clinical Care visit.

The PHP is owned by the Veteran, but it may be populated by many different team members in partnership with the Veteran and over the course of many different visits. The PHP helps to ensure that all involved can easily see the goals and progress the Veteran is making toward their health and well-being. The PHP is not something that is delegated to a particular program or role; it is a shared document, owned by the Veteran, and populated by all involved in supporting the Veteran's health and well-being goals.

There are many important elements in the PHP, including self-reflection, goal setting, and shared goals with healthcare team members. These members may include Whole Health partners, Whole Health coaches, CIH instructors, well-being instructors, clinical team members, and community support.

The process of connecting to the Veteran's MAP and of connecting health care goals to the MAP (shared goal setting) are fundamental aspects of the personal health planning process. Clinical shared goals are documented in the “Professional Care” section of the PHP, and clinical team members and CIH providers can document in this section.

When implementing the CPRS PHP template, facilities will need to ensure the proper infrastructure is in place, and that the proper stakeholders are involved (e.g., CAC, representative clinicians, team members and leaders). Teams will need to understand how each of their roles contribute to the PHP, including the



Veteran's. As such, it can be useful to outline an implementation plan for the PHP that includes building awareness and buy-in for all critical stakeholder groups prior to training or expecting full implementation.

An added benefit of using the national PHP template is that its health factors allow for tracking of specific answers and goals, as well as understanding how the health care team are completing documentation. For additional information on the national CPRS PHP template and Whole Health tracking, please see section 5.7 Setting up Whole Health Documentation and Workload Tracking Tools of this *Guide*.

**The Personal Health Plan (PHP) is a critical component of Whole Health Clinical Care. Regardless of which component of the Whole Health System a Veteran is engaged with, when they see their clinical team, that team will work closely with the Veteran to establish or update their shared goals. These goals will be reflected in an updated PHP for each Veteran and will represent a shared commitment by the clinical team and the Veteran to support achievement of these goals. The PHP is a dynamic document that does not need to be updated at each visit, but rather, updated when a new shared goal is established or modified. Also, the PHP is addressed across all components of the Whole Health System, and it is recommended that sites determine the most efficient process for ensuring coordinated efforts given the unique circumstances at their facility.**

#### 8.4.2 Complementary and Integrative Health (CIH) Approaches

Complementary and integrative health (CIH) approaches can be integral in supporting and developing Veterans' shared goals. **Options for providing CIH approaches include one or more of the following:**

- Clinical team providers may be trained in these approaches
- CIH providers may be embedded within a clinical care team (such as an acupuncturist working in a primary care clinic)
- CIH providers may work within the Well-being Program
- CIH providers may be seen on a consultative basis

**Within the Whole Health System, CIH approaches can be offered either through the Well-being Program (for any interested Veteran, and not based on a particular condition), or within Whole Health Clinical Care (within a specific clinic to support treatment of a specific disease).** In the case of Whole Health Clinical Care, the CIH approach is only offered to the Veterans referred to a specific clinic (e.g., yoga within pain clinic; mindfulness-based stress reduction class within Trauma Services; battlefield acupuncture within PACT). Integration of CIH within clinical care can augment personalized health plan options for Veterans. CIH approaches can be wonderful additions to a clinicians' toolkit, especially as they help Veterans manage their chronic diseases, pain, and mental health conditions. Often, clinicians express excitement over their increased ability to meet the needs of Veterans in addition to learning a new skill for themselves.

The Integrative Health Coordinating Center (IHCC) continually develops resources to educate clinicians in the provision of CIH approaches. For example, VHA has developed an internal clinical hypnosis training and mindfulness facilitator training. It is also developing an internal guided imagery certification program as well as an acupressure skills training. Currently there are eight CIH approaches that have

been reviewed and approved for coverage in the Veterans Medical Benefits Package that show evidence of promising or potential benefit. For more information on CIH approaches, please visit the [IHCC SharePoint site](https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC) (<https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC>).

The following sections present examples of how to implement CIH within clinical care.

#### *8.4.2.1 Battlefield Acupuncture (BFA)*

Battlefield acupuncture (BFA) is a fast, 5-point ear acupuncture protocol which can be utilized as a part of a pain management plan for Veterans. To read more about this protocol, visit the [acupuncture section of the IHCC sharepoint site](https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Acupuncture.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Acupuncture.aspx>).

If providers are interested in training, they can email [vhabfasupport@va.gov](mailto:vhabfasupport@va.gov) for further information. Once trained and privileged to provide this treatment, providers can easily incorporate it into their day-to-day clinical routine. There are several options for doing this, including:

- Group BFA appointments for provider's panel of patients
- Weekly group BFA appointments (multiple 30-minute group appointments or several individual 15-minute appointments) with rotating providers each week
- 30-minute group appointments at the start of a clinic day, offered 2-3 days/week
- Providers can deliver BFA during a clinic visit while examining their patients or taking a history. Given that oral consent is sufficient and there is a national note template for BFA, it is quite easy to provide the service during existing visits. Typically, Veterans will need follow up every 2-3 weeks for several treatments, and therefore, a follow up group clinic can help with access, or referral to an existing BFA clinic.

#### *8.4.2.2 Clinical Hypnosis in Mental Health*

Clinical hypnosis is a complementary approach that can be used as an adjunctive therapy in managing care for Veterans. Many clinicians have found success incorporating clinical hypnosis into existing individual appointments as an option in Veterans' treatment plans. Group hypnotherapy can also be effective and can support productivity needs for clinicians. These visits can be conducted face-to-face or virtually. Those trained in clinical hypnosis will find a variety of potential styles to use that will allow for the necessary brevity if appointment times are short. The key is that this is a skill you are teaching your Veterans to practice, and over time they will be able to utilize this skill as a part of their own ongoing self-care.

There are a variety of indications for the use of clinical hypnosis. A detailed evidence map, coding/tracking recommendations, a 2-page fact sheet, and other resources can be found on the [clinical hypnosis section of the IHCC SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Clinical-Hypnosis.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Clinical-Hypnosis.aspx>).

#### *8.4.2.3 Guided Imagery in Surgery*

The peri-operative phase can be anxiety-provoking for many Veterans. The good news is that approaches such as guided imagery, mindfulness, and meditation can help reduce stress and anxiety. In the pre-operative and post-operative phase, Veterans can use apps, watch, or listen to recordings of guided imagery scripts or meditation practices. Many VA sites offer the use of televisions or devices that



can be preloaded with this content, or have access to VA-approved apps, as long as appropriate infection prevention measures are taken. Alternatively, asking a Veteran to bring in their own recordings of music, meditations, or prayers they find relaxing can assist with anxiety, stress, or pain, and has even been shown to be helpful in creating a safe environment and decreasing risk of ICU delirium.<sup>1</sup>

Additional resources about guided imagery, including an evidence map, 2-page fact sheet, and coding/tracking information can be found on the [guided imagery page of the IHCC SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Guided-Imagery.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/SitePages/Guided-Imagery.aspx>).

#### *8.4.2.4 Barriers and Solutions to Implementation of CIH within Clinical Care Practice*

##### **Barrier #1: Relative Value Units (RVUs) for some CIH approaches can be lower than benchmarks**

###### **Solutions:**

- While this may be true for some approaches, there are ways to appropriately document care and still keep productivity high. The Office of Productivity, Efficiency, and Staffing (OPES) sets and periodically updates guidelines for provider productivity. Visit the [OPES website](http://opes.vssc.med.va.gov/Pages/Default.aspx) (<http://opes.vssc.med.va.gov/Pages/Default.aspx>)
- Work with your local Health Information Management System (HIMS) liaison to verify which CPT codes can be used together to improve RVUs for the visit. There is a national correct-coding initiative which guides this advice and is based on AMA guidance. Your local HIMS POC(s) will be able to advise you based on these standards
- Try group work. This can be a great way to increase your productivity and allow for shared experiences among Veterans. You can often see more people in 60-90 minute groups than you can in individual appointments

##### **Barrier #2: Time**

###### **Solutions:**

- With any new skill there is an increased time commitment. However, most providers find that by delivering these approaches repeatedly, speed improves. This is as true of asking questions about MAP as it is true for CIH approaches such as breathwork, mindfulness, or BFA
- Group work can be beneficial in delivering needed approaches to a few people at the same time
- As you teach Veterans skills for their own self-care and resilience, their reliance on the clinical system may decrease

##### **Barrier #3: Some providers question the evidence-base for CIH**

###### **Solutions:**

- It is essential to understand that these approaches are adjunctive therapies and are not considered to replace other existing evidence-based practices. In many cases, these approaches are skills Veterans can use at home, increasing their autonomy and decreasing reliance (and cost) on the healthcare system
- Several organizations have cited CIH as an appropriate part of care including:
  - [Guidelines for Opioid Prescribing from Joint Commission](https://www.jointcommission.org/-/media/tjc/documents/standards/jc-) (<https://www.jointcommission.org/-/media/tjc/documents/standards/jc->

requirements/2018-

requirements/joint\_commission\_enhances\_pain\_assessment\_and\_management\_requirements\_for\_accredited\_hospitals1.pdf?db=web&hash=1DFAA78F3C6EDD8AA2A1A152D18D4409)

- [Guidelines for Prescribing Opioids in Chronic Pain from CDC](https://www.cdc.gov/drugoverdose/prescribing/guideline.html)  
(https://www.cdc.gov/drugoverdose/prescribing/guideline.html)
- [Guidelines for Low Back Pain from American College of Physicians \(ACP\)](https://www.acpjournals.org/doi/10.7326/M16-2367?_ga=2.93515737.57636561.1592841614-1937379992.1592841613&)  
(https://www.acpjournals.org/doi/10.7326/M16-2367?\_ga=2.93515737.57636561.1592841614-1937379992.1592841613&)
- [Evidence Maps published by VHA HSR&D](https://www.hsrdr.research.va.gov/publications/esp/reports.cfm)  
(https://www.hsrdr.research.va.gov/publications/esp/reports.cfm) can help clinicians in reviewing current evidence
- A **table summarizing common diagnoses and non-pharmacologic approaches to pain** can be found on the [IHCC SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/Shared Documents/Forms/AllItems.aspx?id=%2Fsites%2FVHAOPCC%2FIHCC%2FShared Documents%2FGeneral CIH%2Fd%2E Research and Evidence Maps%2FNon-Pharmacologic Approaches by Condition%2FNon-Pharmacologic Approaches to Clinical Conditions Final_Feb 2021%2Epdf&parent=%2Fsites%2FVHAOPCC%2FIHCC%2FShared Documents%2FGeneral CIH%2Fd%2E Research and Evidence Maps%2FNon-Pharmacologic Approaches by Condition) (https://dvagov.sharepoint.com/sites/VHAOPCC/IHCC/Shared Documents/Forms/AllItems.aspx?id=%2Fsites%2FVHAOPCC%2FIHCC%2FShared Documents%2FGeneral CIH%2Fd%2E Research and Evidence Maps%2FNon-Pharmacologic Approaches by Condition%2FNon-Pharmacologic Approaches to Clinical Conditions Final\_Feb 2021%2Epdf&parent=%2Fsites%2FVHAOPCC%2FIHCC%2FShared Documents%2FGeneral CIH%2Fd%2E Research and Evidence Maps%2FNon-Pharmacologic Approaches by Condition)
- The Complementary and Integrative Health Evaluation Center (CIHEC) has compiled a **library of research for CIH** and database of current research studies that can be found on the [Whole Health Evidence-Based Research page](https://www.va.gov/WHOLEHEALTH/professional-resources/clinician-tools/Evidence-Based-Research.asp) (https://www.va.gov/WHOLEHEALTH/professional-resources/clinician-tools/Evidence-Based-Research.asp)

#### 8.4.3 Whole Health Coaching

Health coaching is an important part of the Whole Health System. As Veterans set shared goals, they will want to address the challenges and barriers to accomplishing those goals. It will also be important to celebrate achievements to help stay motivated. **There are many ways that a clinical team can engage with Whole Health coaching. In addition to working with Pathway and Well-being programs, Whole Health coaches may be embedded within a clinical care team.** No matter where Whole Health coaches are aligned within the organization, they should be easily accessible to clinical care teams.

Integrating Veteran-facing health coaching on a wider scale begins with identifying clinical staff or Well-being staff, or other team members who are interested in committing to OPCC&CT's Whole Health Coaching course. Once Whole Health coaches have been trained, the clinical care team can create a process whereby the team can refer the Veteran to health coaching for further support. For example, a clinical team's Registered Nurse (RN), LPN, or Peer Support Specialist who has successfully completed the Whole Health Coaching course can then easily follow the health goal that was created by the Veteran with the provider. This allows for continuity of care within the clinical team setting. Additionally, many sites hire dedicated Whole Health coaches who are embedded in clinical care teams or who are otherwise easily accessible.

In all of these scenarios, health coaches can help continue the work on shared goals and the development of the Veteran's personal health plan. Coaches meet Veterans where they are and help them work towards goal attainment. They can be essential in helping Veterans attain their shared goals and therefore, be an incredibly important addition to healthcare teams. Furthermore, existing resources within the VA (e.g., MOVE!, smoking cessation programs, and other Health Behavior consults) serve to reinforce the Veteran's health goal and are consistent with the practice of health coaching.

Health coaching is a critical piece of Whole Health System transformation, as these trained professionals work in support of Veterans' goals for health and well-being. Learn more about [Whole Health coach training opportunities on the OPCC&CT Education SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Whole-Health-Coaching.aspx) (https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Whole-Health-Coaching.aspx). Learn more about effective coding, tracking, and documentation for Whole Health coaching and other Whole Health services in section 5.7 Setting up Whole Health Documentation and Workload Tracking Tools of this Guide and on the [WHS Coding and Tracking Guidance SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/SitePages/Whole-Health-System-Coding-Guidance.aspx) (https://dvagov.sharepoint.com/sites/VHAOPCC/SitePages/Whole-Health-System-Coding-Guidance.aspx).

To learn more about Whole Health coaching, visit the [Whole Health Coaching document library](https://dvagov.sharepoint.com/sites/VHAOPCC/Shared%20Documents/Forms/AllItems.aspx?RootFolder=/sites/VHAOPCC/Shared%20Documents/Whole%20Health%20Coaching&FolderCTID=0x01200092D5EAC253479641B8D0A20FE4165E94&View=%7b4AD754A9-57D5-4A13-A317-D62DAB4881EB%7d) (https://dvagov.sharepoint.com/sites/VHAOPCC/Shared%20Documents/Forms/AllItems.aspx?RootFolder=/sites/VHAOPCC/Shared%20Documents/Whole%20Health%20Coaching&FolderCTID=0x01200092D5EAC253479641B8D0A20FE4165E94&View=%7b4AD754A9-57D5-4A13-A317-D62DAB4881EB%7d).

#### *8.4.3.1 Integrating Whole Health Coaching into Clinical Care*

Integrating health coaching into clinical care requires a systematic, often iterative, plan. This is because different service lines, different patient populations, and different facilities will have unique needs. Many times, clinicians eventually enjoy having health coaching as a resource because it allows them to connect their Veterans to a service that they don't necessarily have the time or training to pursue. Sites can monitor the extent of utilization and integration of health coaches through health factors, note titles, clinic encounters, personal health plan entries or consults.

Because integration of Whole Health coaching can represent a behavioral change for clinician workflow and process, it is important to think of strategies to make coaching easily accessible and to continually educate, communicate, and remind providers of its value. This can be done through Veteran testimonials from their panels of Veterans, activation or goal attainment measures, assessment of biometric improvements (HbA1c, BP, BMI), medication reductions, etc.

**Based on the experiences of several sites implementing Whole Health coaching, the following recommendations may prove successful for your site's implementation plan:**

- Align the Whole Health coach with an individual provider (either shadowing actual visits or automated referrals from their panel after the LPN/RN scrubs the list)
- Embed a referral to a Whole Health coach into clinician workflow (RTCs, routing slips, new patient visits, discharge orders)
- Embed the Whole Health coach into a clinical area or CBOC
- Create a specific consult or e-consult for Whole Health coaching
- Make a Whole Health coach visit a requirement for attendance at a CIH class or approach

- Have a Whole Health coach co-facilitate *TCMLH* with a Whole Health partner to familiarize Veterans with the coach
- The Whole Health coach can attend huddles and team meetings to raise awareness of this resource while discussing patient needs
- Establish a process for a PCMH warm hand-off when the Veteran is stabilized
- Offer peri-operative health coaching to assist known mental health and pain management self-care skills
- Associate a Whole Health coaching referral with inpatient discharges
- Offer virtual Care Management appointments for coaches as a part of new visits or existing clinical appointments (virtual warm hand-off)

Whatever approach(es) a site decides to use, trial a few and evaluate recruitment efforts. While there is no absolute dose, literature suggests that 8-12 visits may be necessary to help people set and progress on their goals.<sup>1</sup> If you are noting only one or two visits before disengagement, it may be wise to include other approaches for recruiting Veterans into the coaching process. Keep in mind, if Veterans are not activated or engaged in their health and well-being, they may not be motivated to try coaching. It may be a good idea to start first with a Whole Health orientation or an exploration of their PHI (through *TCMLH* or an individual Whole Health partner visit). Alternatively, they may want to try a Well-being or self-care approach first and then become activated around a goal and coaching. There is no wrong way into a Whole Health approach to care, and it is helpful to have all clinicians, instructors, and CIH providers encouraging Veterans to self-explore what matters most to them.

#### *8.4.3.2 Clinician Coaching*

**Clinical providers and teams can also work on their own skills surrounding motivational interviewing and coaching.** NCP offers clinician coaching trainings that play an important role in improving the fundamental communication skills necessary to support the setting of shared goals in the clinical setting. These trainings are TEACH for Success (known simply as “TEACH”) and Motivational Interviewing (MI). NCP’s TEACH and MI facilitators are available at many sites to help PACT teams and other clinicians apply these skills in actual practice. NCP provides extensive training and support to TEACH and MI facilitators to prepare them to serve as clinician coaches. Clinician coaches provide coaching in both individual and group settings. Clinician coaches are available for individual case consultation to assist clinicians with Veteran-centered communication and health coaching approaches. Whole Health System implementation provides a great opportunity to support and expand clinician coaching in the use of effective Veteran-centered communication strategies.

In addition, OPCC&CT offers a *Whole Health Coaching for Providers* course. For further details about this and other courses, refer to [OPCC&CT Education SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Home.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Home.aspx>).



*Myth #6: “Veterans don’t want this.”*

*A national evaluation survey of 1395 Veterans at the 18 Flagship Sites showed that 97% of Veterans want a Whole Health approach. An even larger percentage wanted to engage with a Whole Health clinician, defined as someone who asks “what matters most to them”. Reports from the Center for Evaluating Patient Centered Care (EPCC) evaluating the Whole Health System of Care at the Flagship Sites can be found on the [OPCC&CT Research & Evaluation SharePoint](https://www.va.gov/WHOLEHEALTH/professional-resources/clinician-tools/Evidence-Based-Research.asp) (<https://www.va.gov/WHOLEHEALTH/professional-resources/clinician-tools/Evidence-Based-Research.asp>).*

## 8.5 Bringing it all Together: Integrate Fundamentals, Shared Goal Setting (Map to the MAP), and Equip into Whole Health Clinical Care

For Whole Health Clinical Care to truly reach its full potential, it must be conducted continuously and synergistically with the other components of the Whole Health System, so that Veterans are fully empowered and equipped to live their life to the fullest in support of their MAP. Whole Health Clinical Care is achieved when these steps are completed and then repeated on a routine basis. When this happens, Whole Health Clinical Care becomes the standard in which clinical care is delivered by the individual, team, program and system. System-wide transformation happens when the Veteran’s MAP and Personal Health Plan guide collaborative decisions between the clinical team and the Veteran.

Integrating the resources available via the Pathway and Well-being components can be especially helpful to introduce Veterans to Whole Health concepts, as well as to aid them in addressing self-care and related educational needs. Documentation is important along the way, as is measurement to assess the impact of this approach and allow for coordination of care. Measurement strategies should be in place to assess impact of Whole Health approach in a fully designated Whole Health clinical care team.

Throughout this process, it is essential that clinical teams are learning and focusing on their own Whole Health and celebrate progress along the way. For additional information, refer to section 9. Employee Whole Health Domain of this *Guide*. Preliminary outcomes from the 18 Flagship Sites for Whole Health System implementation show a correlation between application of Whole Health and clinician burnout, satisfaction, and turnover intentions. By practicing care that focuses on personalization and long-term goal attainment, employees often feel more fulfilled in their day to day work. Employee resilience is a priority in order to deliver high-quality care for our Veterans.

Fundamentally, this journey is about learning the process of identifying and prioritizing your Veteran’s MAP and self-care goals, connecting it to shared goals, and informing your personal health planning process. Ultimately, Veterans will have their own Personal Health Plan, and as they transform into their own advocate for their health and well-being, we will ideally see outcomes transform as well.

The sections that follow provide the reader with key operational tactics to pursue this transformation.



*Myth #7: “There’s no evidence for this.”*

*Over the last few decades, significant strides have been made in creating and communicating evidence for personalized health care and CIH utilization. There is evidence that such care can improve quality of life and assist in management of chronic disease and illness. See [References at the end of this chapter](#).*

## 8.6 Operationalize Whole Health Clinical Care

Over the past several years, much has been learned and shared from teams, facilities and VISNs that inform how Whole Health Clinical Care may best be operationalized. In this section, key recommendations are shared based on the progress made by these early adopters and champions.

### 8.6.1 Governance and Leadership

Establishing Governance, and ensuring accountability and ownership, is necessary and cannot be over emphasized. Many sites have started efforts in transformation Whole Health Clinical Care, only to find that they are unable to progress due to lack of governance. Active and visible leadership and sponsorship are critical to cultural transformation, and this is at multiple levels. Involving key influential leaders at the executive level, supervisory level, and front-line level will ensure a system-wide approach to transformation.

### 8.6.2 Change Management

Planning for and addressing the people side of change increases the efficiency and outcomes of transformation, regardless of scale, and is a necessity for true cultural transformation. Commonly termed “Change Management,” there are many models and methods available. The change model being used by VHA in support of the Modernization Plan is the Prosci model, which addresses three key phases of change management along with the five building blocks of individual change (Awareness, Desire, Knowledge, Ability and Reinforcement – ADKAR). The National Center for Organizational Development provides a streamlined approach to managing change using this approach via their [SmartChange Toolkit](https://vaww.vashare.vha.va.gov/sites/NCOD/SitePages/SmartChange/SmartChangeHome.aspx) (<https://vaww.vashare.vha.va.gov/sites/NCOD/SitePages/SmartChange/SmartChangeHome.aspx>).

### 8.6.3 Capture “Current State”

Reviewing available clinical care offerings or approaches and determining which are consistent with a Whole Health approach to care will form the basis of a site’s current state assessment, and a foundation from which a gap analysis and associated action planning can be completed. Refer to the characteristics of Whole Health Clinical Care in section [8.2 Fundamentals of Whole Health Clinical Care](#) of this chapter for more information on what comprises a Whole Health approach to clinical practice. As mentioned, many clinicians may already embody some of these characteristics, and it’s important to validate this and meet them where they are at right now. We also highly recommend a current state assessment of leadership, middle management, and frontline staff’s readiness for change as well.

### 8.6.4 Long-Term Aim, Goals and Action Planning

After conducting a current-state assessment and before selecting a near-term goal, the longer-term Aim should be established. This is the “future state.” The Aim(s) can be informed by the [Designation Framework for Whole Health Implementation](#) (<https://dvagov.sharepoint.com/:w:/s/VHAOPCC/EUdWEp9OfqtGt3wL4-VZ3mIBIRzn6chrEYAyqfc7ffTdyw?e=flmsq5>) and associated accomplishments. Aims will be more successful if they are co-created with the team or individual making the change. Instead of directing a team or individual on how to change, work with them to understand why change is helpful and develop a plan together on how change can be achieved. This is not much different from using motivational interviewing and behavior and lifestyle change management principles with Veterans. The short- and

mid-range goals necessary to achieve that Aim can then be determined, and a corresponding action plan should be developed. Importantly, it is appropriate to start with building awareness and desire before diving immediately into training or implementation of a new skill or change, and to set near or short-term goals based on the current reality of the site and/or team.

#### 8.6.5 Champions

Over the past several years, many facilities have designated local Whole Health clinical champions that help the clinical team integrate the Whole Health approach into their practice by offering Whole Health education, information on local or community-based Whole Health resources, connectivity to education and training, as well as coaching, case reviews, and consultation. Most recently, as a result of the Transforming Healthcare Delivery Whole Health Modernization Lane, the role of **Whole Health Integration Champions (WHIC)** has been established. For more information on the required WHIC role, please see the [Whole Health Clinical Care Domain SharePoint site](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WH_Clinical_Care_Domain/Forms/AllItems.aspx?viewid=30195a8a%2D76f5%2D48ef%2D8581%2Dce09f5374c18&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FWH%5FClinical%5FCare%5FDomain%2FLocal%5FClinical%5FChampion%5FResources) ([https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WH\\_Clinical\\_Care\\_Domain/Forms/AllItems.aspx?viewid=30195a8a%2D76f5%2D48ef%2D8581%2Dce09f5374c18&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FWH%5FClinical%5FCare%5FDomain%2FLocal%5FClinical%5FChampion%5FResources](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WH_Clinical_Care_Domain/Forms/AllItems.aspx?viewid=30195a8a%2D76f5%2D48ef%2D8581%2Dce09f5374c18&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FWH%5FClinical%5FCare%5FDomain%2FLocal%5FClinical%5FChampion%5FResources)).

Clinicians in any of these roles should have convenient access to the extensive repository of Whole Health tools for providers housed in the [OPCC&CT Whole Health Library](https://www.va.gov/WHOLEHEALTHLIBRARY/get-started/index.asp) (<https://www.va.gov/WHOLEHEALTHLIBRARY/get-started/index.asp>). By working with a knowledgeable local champion, teams can learn how to integrate and better understand both Whole Health and the use of the personal health planning process that culminates with a PHP in CPRS/EHR for use by the broader Veteran care team. Additionally, the local Whole Health Clinical Care champion can also be a proponent for the importance of clinician self-care, which is another characteristic of Whole Health Clinical Care.

For more information, please review the [Clinical Champion – Lessons Learned from Flagship Sites document](https://www.va.gov/WHOLEHEALTH/docs/Whole_Health_Training_Lessons_Learned_Final_06012021.pdf) ([https://www.va.gov/WHOLEHEALTH/docs/Whole\\_Health\\_Training\\_Lessons\\_Learned\\_Final\\_06012021.pdf](https://www.va.gov/WHOLEHEALTH/docs/Whole_Health_Training_Lessons_Learned_Final_06012021.pdf)).

#### 8.6.6 Piloting Implementation of Whole Health Clinical Care

Once the Aim and associated near-term goals are determined (including change management considerations), most sites elect to engage with service lines that exhibit key characteristics for success. Those characteristics include:

- The team is already doing Whole Health-related work
- Engaged leadership
- Willing staff

It is recommended that any teams selected to pilot a change should also have the opportunity to weigh in on their readiness for change, the goals they are working toward, and the steps being planned to achieve those goals.



Once the newly developed process(es) have been under way for a trial period (ranging from 30–120 days), consider creating an opportunity for the individuals or teams to reflect upon how it is going, and to take any needed steps to advance their skills for implementation. For example:

- Clinicians can practice needed skills with one another in a group setting while having a champion (local) or SME (e.g., FIT) or similar expert present to provide coaching. Consider using local staff who have training in Clinician Coaching and Whole Health, such as Health Behavior Coordinators
- If the team or clinician is comfortable doing so, “shadowing” can be considered, during which a champion or other expert sit in on appointments to provide coaching and feedback. If shadowing is conducted, ensure there is consent from all parties, and that the process is not used in any way that is punitive or related to formal performance assessments

**In addition to core clinical staff, there are several other roles that support the work of Whole Health in conjunction with the Whole Health Clinical Care team, as described below.** The team should meet with the appropriate Whole Health champions or subject matter experts to discuss education, training, and resources.

- MSAs have a working knowledge of the components of health and well-being (i.e., what it encompasses). MSAs can develop scripts to use when presenting Whole Health to Veterans, they can hand out brochures, encourage participation in *Introduction to Whole Health*, hand out PHIs, etc. Script development could be accomplished by an MSA group as a learning opportunity about Whole Health and their role. MSAs are often the face of the team. Thus, consistent Whole Health language is important and begins with them
- Additional support roles can include Licensed Practical Nurses (LPNs)/Vocational Nurses, and Health Technicians
- Some teams will choose to integrate one or more CIH approaches into clinical care, in addition to being able to refer to these services through the Well-being Programs
- A Whole Health coach or partner may be embedded into the clinical team

Once the initial pilot is complete, the site is ready to refine the approach —as many times as needed and to the extent necessary to ensure a positive Veteran and staff experience of care. Once the Whole Health approach is successfully integrated with the clinical process of the pilot teams, the work is not yet complete. Rather, there are spread and sustainment activities necessary to ensure ongoing compliance and improvement. At a certain point, which will be different for every site, the pilot teams will have achieved a form of clinical care transformation that will be suitable for spread to other clinical environments.

#### 8.6.7 Operationalizing Personal Health Planning in Whole Health Clinical Care

Using the Whole Health approach in clinical care includes conducting personal health planning. This activity informs the completion of the Veteran’s Personal Health Plan, and includes the process of identifying MAP, connecting goals to the MAP, and equipping Veterans with resources to support their pursuit of those life and/or health goals. **The figure below illustrates how the development and implementation of a Veteran’s PHP is supported in the pre-clinician and post-clinician phases of the Veteran’s journey, in addition to the conversations that occur during the clinic visit.**



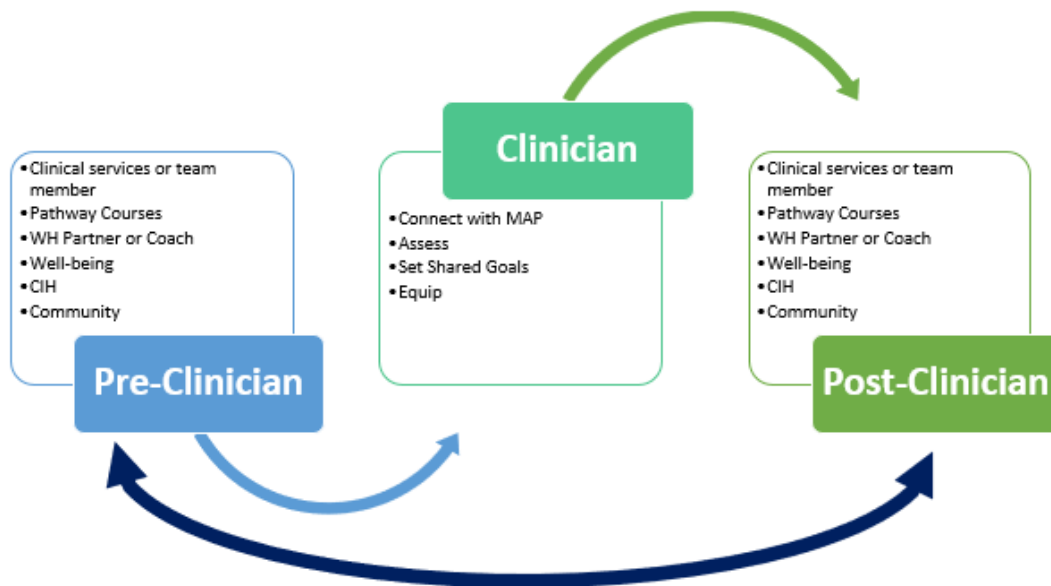


Figure 9: Personal Health Plan Support and Development

**Tips for implementing personal health planning in Whole Health Clinical Care include:**

- When a Veteran presents to clinical care with a PHP already started and MAP identified: The clinical care team should review and discuss the plan with the Veteran and confirm the MAP. Then, the team should work with the Veteran to set shared goals (and related SMART goals), thereby expanding the PHP
- When a Veteran presents to the clinical care team without a PHP and is interested in creating one: The team should provide an overview of personal health planning and offer to begin the Veteran's process of identifying their MAP and setting shared goals and related SMART goals, if desired. Responsibility for these actions should be shared across team members whenever possible, and action is likely to occur across multiple encounters
  - Basic actions for conducting personal health planning in a Whole Health Clinical Care setting include traditional care planning and management guided by the establishment of shared goals
  - Document in CPRS using a PHP template that will be viewable to others in the VHA system, and ensure the Veteran has a copy of their PHP
- Capturing Whole Health Clinical Care can be done through many methods, including:
  - Whole Health System health factors can be embedded into encounter forms or into reminder dialogue templates. See the [WHS Coding and Tracking Guidance](https://dvagov.sharepoint.com/sites/VHAOPCC/SitePages/Whole-Health-System-Coding-Guidance.aspx) (https://dvagov.sharepoint.com/sites/VHAOPCC/SitePages/Whole-Health-System-Coding-Guidance.aspx) for information on uploading the national Whole Health encounter form
  - WH-PHP health factors:
    - The PHP is Veteran owned and is filled out by multiple team members over time. It is not meant to be a comprehensive clinical treatment plan or a substitute for medical plans in CPRS/EHR. This is an important document, however, in that it defines a Veteran's MAP, self-care goals, shared goals with

clinicians or CIH instructors, and community supports. Over time, we each hope to own our own personalized health plan and live from it on a daily basis, modifying it as needed to maintain our health and wellbeing. The PHP is a national template (reminder dialogue) and has embedded health factors for each field to allow for ease of tracking implementation at a national level. The

[Whole Health health factor dashboard](https://dvagov.sharepoint.com/sites/VHAOPCC/sitePages/Whole-health-dashboards.aspx)

(<https://dvagov.sharepoint.com/sites/VHAOPCC/sitePages/Whole-health-dashboards.aspx>) is accessible here, and progress can be tracked by facility or VISN

- WH-PHP health factors can also be individually embedded into existing reminder dialogue templates at your facility and still be tracked nationally. Examples include:
  - Shared goals in primary care notes
  - MAP in mental health notes
- In order to pull national health factors into existing facility templates, you must be using a reminder dialogue template. Health factors cannot be pulled into personal templates or Word documents
- PHI template: A national PHI template is available. For additional information, including FAQs, please see the material posted in the [National Note Templates folder on SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x012000965D235B81AE9A40B070A146F202ECC1&viewid=4ba2c7d3%2Dd49a%2D456c%2D49a%2Db6b2153c997b&id=%2Fsites%2FVHAOPCC%2FShared%20Documents%2FCIH%20Coding%20Guidance%2FNote%20Title%20Templates%2FNational%20Note%20Templates) (<https://dvagov.sharepoint.com/sites/VHAOPCC/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x012000965D235B81AE9A40B070A146F202ECC1&viewid=4ba2c7d3%2Dd49a%2D456c%2D49a%2Db6b2153c997b&id=%2Fsites%2FVHAOPCC%2FShared%20Documents%2FCIH%20Coding%20Guidance%2FNote%20Title%20Templates%2FNational%20Note%20Templates>)
- CHAR 4 code- IDHC: The Whole Health Clinical Care CHAR 4 code “IDHC” can be used when the clinical encounter (team or individual) addresses the Veterans’ Mission/Aspiration/Purpose (MAP) as the foundation from which shared clinical goals are created and equips the Veterans with needed clinical services, education (including self-care and skill building education), complementary and integrative health referrals, and/or other resources directly in support of those shared goals (and thus, MAP)
- Clinical reminders for MAP, PHI, Shared goals, PHP, etc. can be used at the facility’s discretion. However, this is highly recommended as a late-stage implementation option, if at all

#### 8.6.8 Evaluation

When evaluating progress toward goals or outcomes associated with change, there are multiple considerations.

Impact on Veteran experience is an essential measure of success, and we want to ensure Veterans feel empowered and equipped to meet their health and well-being goals and live their lives to the fullest.

These Veteran-facing questions become important then, as we evaluate our strategies and implementation:

1. Does my healthcare team focus on what matters most to me in my life?
2. Do we set goals together that will help me live my life to the fullest?

3. Do I feel equipped with the knowledge and resources to achieve my goals in support of what matters most to me?

Change management assessments can help determine if clinical care teams are accomplishing transformation over time. Conducting Prosci ADKAR assessments before beginning your work, and then over the course of growth, are a nice way of showing teams their successes and for mapping the necessary support methods needed along the way. For example, if the pilot individual or teams are in an early stage of change (Awareness), focusing on education and employee Whole Health self-care support might be the right next steps. If, instead, the individual or team is in a more advanced stage of change (Ability), then supporting with tools such as the personal health plan or health coaching would be appropriate.

As clinical teams evolve on this journey towards a more fully integrated Whole Health System of care, it will become important to evaluate how this transformation is affecting clinical team members, and most importantly, Veteran outcomes. These outcomes may include Veteran satisfaction, quality indicators such as patient-reported outcome measures, or improvement in clinician-patient interactions. Refer to OPCC&CT's [Whole Health Evaluation Toolkit](https://dvagov.sharepoint.com/sites/VHAOPCC/Shared%20Documents/Forms/AllItems.aspx?RootFolder=/sites/VHAOPCC/Shared%20Documents/Research/1.OPCCCT%20Research%20Projects/Evaluation%20Toolkit/WH_Evaluation_Toolkit&FolderCTID=0x01200092D5EAC253479641B8D0A20FE4165E94&View=%7b4AD754A9-57D5-4A13-A317-D62DAB4881EB%7d) ([https://dvagov.sharepoint.com/sites/VHAOPCC/Shared%20Documents/Forms/AllItems.aspx?RootFolder=/sites/VHAOPCC/Shared%20Documents/Research/1.OPCCCT%20Research%20Projects/Evaluation%20Toolkit/WH\\_Evaluation\\_Toolkit&FolderCTID=0x01200092D5EAC253479641B8D0A20FE4165E94&View=%7b4AD754A9-57D5-4A13-A317-D62DAB4881EB%7d](https://dvagov.sharepoint.com/sites/VHAOPCC/Shared%20Documents/Forms/AllItems.aspx?RootFolder=/sites/VHAOPCC/Shared%20Documents/Research/1.OPCCCT%20Research%20Projects/Evaluation%20Toolkit/WH_Evaluation_Toolkit&FolderCTID=0x01200092D5EAC253479641B8D0A20FE4165E94&View=%7b4AD754A9-57D5-4A13-A317-D62DAB4881EB%7d)) for further assistance with measuring outcomes.

**Some examples of patient reported outcome measures which are already being used in the Center for Evaluating Patient-Centered Care (EPCC) Flagship Site evaluation are:**

*Table 8: Examples of Whole Health Patient Reported Outcome Measures*

Key Outcomes	Likely Measures
<b>Sense of life meaning and purpose</b>	<ul style="list-style-type: none"> <li>Life Engagement Test</li> <li>IHI/100 Million Healthier Lives measure</li> </ul>
<b>Engagement in health care and management</b>	<ul style="list-style-type: none"> <li>Perceived Health Competency Scale</li> <li>Altarum Consumer Engagement (ACE)</li> <li>IHI Measure</li> </ul>
<b>Goal setting and attainment</b>	<ul style="list-style-type: none"> <li>Goal attainment questions adapted from the FY15 PHP survey</li> </ul>
<b>Perceived improvement in health and well-being</b>	<ul style="list-style-type: none"> <li>Perceived Stress Scale (PSS)</li> <li>PROMIS-10 (functional outcomes)</li> <li>Social Support (Partners in Care)</li> </ul>
<b>Experience of pain</b>	<ul style="list-style-type: none"> <li>Site of Pain and Pain Chronicity (IMPROVE QUERI)</li> <li>Defense and Veterans Pain Rating Scale (DVPRS)</li> <li>Pain, Enjoyment, General Activity (PEG)</li> </ul>

Key Outcomes	Likely Measures
<b>Patient Centered Care (Healing Relationships)</b>	<ul style="list-style-type: none"> <li>• CollaboRATE</li> <li>• Consultation and Relational Empathy (CARE)</li> <li>• Satisfaction with Care</li> </ul>



**Myth #8: “This won’t change outcomes.”**

*Personalized health planning has been linked with improvement in goal setting and attainment and chronic disease management. Patient-centered care is associated with improvement in Veteran satisfaction and provider satisfaction.* [1.2.3.4](#)

Establishing evaluation methods as you begin this work can set you up for measurable long-term success. It is essential to set up proper coding and tracking methods early in your efforts, and you can find information on this process in the [WHS Coding and Tracking Guidance](https://dvagov.sharepoint.com/sites/VHAOPCC/SitePages/Whole-Health-System-Coding-Guidance.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/SitePages/Whole-Health-System-Coding-Guidance.aspx>), and/or by reaching out to your primary FIT Consultant. Staff who are addressing coding and tracking for Whole Health Clinical Care should ideally be coordinating with the local facility’s Whole Health director/lead. The following table further explains the value of different coding and tracking mechanisms for the evaluation of Whole Health utilization, workload, and productivity. For further information about coding and tracking, refer to section 5.7 Setting up Whole Health Documentation and Workload Tracking Tools of this *Guide*.

*Table 9: Tracking Mechanisms for Whole Health Clinical Care*

Tracking Mechanism Type	Tracking Applications
<b>Clinic Stop Codes</b> (Count and Non-Count)	<ul style="list-style-type: none"> <li>• Whole Health Utilization and Demand</li> <li>• Workload (with proper labor mapping)</li> <li>• National Evaluation of Whole Health Implementation</li> <li>• VERA (when combined with certain CPTs)</li> </ul>
<b>CHAR4</b>	<ul style="list-style-type: none"> <li>• Whole Health Utilization and Demand</li> <li>• National Evaluation of Whole Health Implementation</li> </ul>
<b>Procedure Codes</b> (CPT)	<ul style="list-style-type: none"> <li>• Whole Health Utilization and Demand</li> <li>• VERA</li> <li>• Productivity</li> <li>• National Evaluation of Whole Health Implementation</li> </ul>

Tracking Mechanism Type	Tracking Applications
<b>Integrative Health Note Title</b>	<ul style="list-style-type: none"> <li>• Whole Health Utilization and Demand</li> <li>• National Evaluation of Whole Health Implementation</li> </ul>
<b>Health Factors</b>	<ul style="list-style-type: none"> <li>• Whole Health Utilization and Demand</li> <li>• National Evaluation of Whole Health Implementation</li> </ul>

Whole Health Clinical Care represents a cultural transformation in our collective clinical practice which requires evaluation tactics that differ from standard program implementation efforts. Because this requires a change to existing practices instead of building a new program, clinic, service line or role, and represents a transformation in “how” we engage with Veterans, measurement is challenging. With the advent of WH System Health Factors, Health Factors associated with the national Personal Health Plan and Personal Health Inventory templates, and WHCC CHAR4 codes, we are now able to offer a rubric for capturing the best “representation” of WHCC possible without the significant investment of a detailed chart review and that will require minimal additional documentation for the clinician. The rubric and other WHCC documents can be found on the [Whole Health Clinical Care Domain SharePoint site](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WH_Clinical_Care_Domain/Forms/AllItems.aspx?viewid=30195a8a%2D76f5%2D48ef%2D8581%2Dce09f5374c18&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FWH%5FClinical%5FCare%5FDomain%2FGeneral%5FImplementation%5FResources) ([https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WH\\_Clinical\\_Care\\_Domain/Forms/AllItems.aspx?viewid=30195a8a%2D76f5%2D48ef%2D8581%2Dce09f5374c18&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FWH%5FClinical%5FCare%5FDomain%2FGeneral%5FImplementation%5FResources](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WH_Clinical_Care_Domain/Forms/AllItems.aspx?viewid=30195a8a%2D76f5%2D48ef%2D8581%2Dce09f5374c18&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FWH%5FClinical%5FCare%5FDomain%2FGeneral%5FImplementation%5FResources)).

Your evaluation efforts over time can also include health outcomes, and while these may take several months to years to become apparent, choosing your tools for measurement can be an early first step. Many sites are monitoring biometrics as a part of their long-term strategy, such as improvements in HbA1c, BMI, and blood pressure or decrease in pain medication usage. Some teams may choose to track health factors for MAP or shared goals, others may choose to track entries of PHIs or PHPs. Additionally, some sites are monitoring the Veteran experience as an important outcome. It is a good idea to engage your key stakeholders (research, quality improvement, data analysts, AES coordinators, etc.) when setting up your evaluation strategy for WHCC transformation.

Another method of tracking integration is monitoring utilization of other key elements of the Whole Health model of care, such as Pathway classes, health coaching, and well-being/self-care approaches. This can be through tracking of CHAR 4 codes, consults, or encounters and unique Veterans. Measuring uptake of the personal health plan, through note titles or health factors, can also be a barometer of change across a system.

In true transformation, you will note increased positive Veteran testimonials and improved clinical team-Veteran satisfaction over time (SHEP, V-signals, and other real-time feedback tools can be excellent methods), and improved clinical team member satisfaction. These changes are expected to be slow and steady, not immediate. Patience and perseverance will be critical skills as you implement these changes. Take time to learn from challenges and successes and from other clinical teams making these

efforts in your facility, your VISN, and across the country. The [EPCC/QUERI evaluation of the initial 18 Flagship sites](https://www.va.gov/WHOLEHEALTH/professional-resources/clinician-tools/Evidence-Based-Research.asp) (https://www.va.gov/WHOLEHEALTH/professional-resources/clinician-tools/Evidence-Based-Research.asp) shows some exciting early outcomes which support the use of comprehensive Whole Health care for Veterans. The final Flagship evaluation report, along with other related reports, will be housed on the [OPCC&CT Research & Evaluation SharePoint](https://www.va.gov/WHOLEHEALTH/professional-resources/clinician-tools/Evidence-Based-Research.asp) (https://www.va.gov/WHOLEHEALTH/professional-resources/clinician-tools/Evidence-Based-Research.asp).

The Whole Health System transformation has been underway for several years, and we now have great examples of innovative practices across the country. It's exciting to promote this type of creativity, and VHA OPCC&CT is always collecting examples of these best practices to share with others. We have seen an emergence of virtual methods for delivering care, virtual reality for populations who otherwise have difficulty with those same real-world scenarios (SCI, PTSD), and shared medical appointments that combine Whole Health education, CIH, and clinical care in each appointment. Sites should encourage, track, and share these innovative approaches. The Whole Health System is a healthcare delivery model that also empowers clinical teams to evolve to meet the needs of a dynamic society. Consider submitting your innovative clinical practices through [OPCC&CT's Whole Health LEAF portal](https://leaf.va.gov/NATIONAL/10NE/Whole_Health/) (https://leaf.va.gov/NATIONAL/10NE/Whole\_Health/) by using the *Request to Present to WH Practice Subcommittee* form.

#### *8.6.8.1 Evaluating Clinician Adoption of Whole Health Behaviors*

There are also several ways to track clinician adoption of Whole Health Clinical Care behaviors, including the measurement of:

- Use of motivational interviewing techniques (direct observation)
- Asking about and incorporating MAP into daily care (health factors, PHI, PHP)
- Creating shared goals (health factors, PHP)
- Equipping Veterans with skills and resources to accomplish goals (referrals, consults, PHP, note titles)
- Integrating with other elements of the Whole Health System (referrals, consults, PHP)

Performance appraisals and Pay for Performance processes might also be utilized. However, appropriate consultation with both leadership and clinicians is necessary before developing performance metrics and prior to using this method for incentive and evaluation. Based on the current phase of Whole Health implementation (per the facility's self-assessment of progress based on the *Designation Framework for Whole Health Implementation*), sites have many options. Some suggestions for performance assessment, based on field experience, are listed below:

- Describing how Whole Health applies to you as a clinician (could be a written or video submission of testimonial)
- Whole Health education attended (face-to-face trainings such as WH102, WH202, and/or other virtual TMS options)
- Use of MAP and/or PHI
- Setting shared goals/use of PHP
- Percentage of panel involved in Whole Health approaches, such as:
  - Orientation to Whole Health

- TCMLH
- Coaching
- CIH
- Well-being skill-building classes
- Involvement in employee Whole Health Well-being options

Note that OPCC&CT has not released formal guidance or recommendations at this time regarding Whole Health performance standards, as we are still learning about best practices from the field. However, field examples of performance standards/competencies are shared via the [Whole Health Positions SharePoint library](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WHHumanResources/Forms/AllItems.aspx?viewid=81726be2%2D9a7a%2D41d3%2D9af2%2D6c06f7dc0d21&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FWHHumanResources%2FWH%5FPositions) (<https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WHHumanResources/Forms/AllItems.aspx?viewid=81726be2%2D9a7a%2D41d3%2D9af2%2D6c06f7dc0d21&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FWHHumanResources%2FWH%5FPositions>) on the OPCC&CT website.

## 8.7 Implementation Lessons Learned

### 8.7.1 Start Small to Win Big

It is critical to set goals that are aligned with the facility's/VISN's overall aim for Whole Health Clinical Care transformation. In doing so, ensure they are SMART goals. For example, if you are starting with pilot teams, it is reasonable to start with 1-3 goals. You must factor in any action items related to address awareness, desire and knowledge prior to conducting formal training or requiring changes to process, procedure or practice. We have learned that it can take 3-6 months for a new practice to be sufficiently tested.

*Example Goal: In support of reaching Phase 2 of the Designation Framework, 3 PACT (or other teams) will begin changing the conversation to address “what matters most” with 80% of new patients over 6 months.*

### 8.7.2 Use the Right Tool at the Right Time

There are many tools and resources now available to support Whole Health Clinical Care transformation. Rather than build a goal around the available tools, it is more effective to start with the goal and then determine the tools or resources needed to support it (just as we would do in practice when working on shared goal setting with our Veterans).

*Example: To support addressing “what matters most” in the goal above, the team may benefit from including the question in pre-appointment paperwork or assessments. The teams may also benefit from first watching a brief online training (such as the Fundamentals of Whole Health), and then attending a short in-person or virtual training (such as Whole Health 202) on using this approach and associated skills in clinical care settings.*

### 8.7.3 Education is Necessary but Insufficient

Many sites have required staff to attend Whole Health trainings. While this is helpful for broadening awareness and knowledge, it *is not sufficient* as a stand-alone tactic for facilitating change. Facilities who have used various educational courses strategically, as part of a plan that includes addressing these needs, have had improved success with facilitating change. For more information, please review the Whole Health Training - [Lessons Learned from Flagship Sites](#)



([https://www.va.gov/WHOLEHEALTH/docs/Whole\\_Health\\_Training\\_Lessons\\_Learned\\_Final\\_06012021.pdf](https://www.va.gov/WHOLEHEALTH/docs/Whole_Health_Training_Lessons_Learned_Final_06012021.pdf)).

Example: Before sending teams to training, the frontline supervisor(s) discuss Whole Health with the pilot team members and assesses their readiness and willingness to serve in this role. They discuss Whole Health in clinical care, why the VHA is working toward this transformation, what would change and what wouldn't, and "what's in it for me" in terms of how the pilot teams could expect to benefit from this approach and participating in pilot work. Team members have a chance to share concerns and to have an active role in determining the way forward, including revising the goals if needed. Once onboard, they may attend a training. The supervisor will have worked with them to outline clear expectations of what will change as a result. They will receive coaching in any necessary skills, have opportunities to problem solve as a group, and their progress will be reinforced in ways that are meaningful to the teams.

#### 8.7.4 Involve the Right People

Leadership sponsorship and the involvement of key stakeholders are critical for cultural transformation. Oftentimes, Whole Health leads (actual titles may differ) have been expected to facilitate change for programs or clinicians over which they have no supervisory authority. If the direct supervisor or ACOS is not on board and actively involved with the work, or is conveying a message that differs from other supervisors or Whole Health leads, the effort is more likely to be significantly prolonged or even fail. Additionally, key stakeholders for programs or processes likely to impact the team's success, or be impacted by the team's changes, should be involved in the process as well.

Example: As noted above, the frontline supervisor for the pilot teams should be onboard with Whole Health Clinical Care transformation, in advance of selecting pilot teams, so that they can provide active and visible leadership and direction to the teams. The Whole Health lead or POC can then serve as the SME or internal consultant to provide guidance, information and coaching to those team members. For frontline supervisors to be on board with transformation, their supervisory chain must also be on board.

#### 8.7.5 Growth Often Requires Setbacks

A majority of sites pursuing WHCC transformation have revised their processes as a result of pilot efforts. This is to be expected. Not every plan or idea will work perfectly in the beginning, and approaching each effort with a "Plan, Do, Study, Act" approach will aid the process over time. This will allow for the process to be informed by results, and to be modified as needed before it is spread to additional teams.

Example: If the pilot teams elect to start by having the Veteran complete a PHI by mail prior to their first appointment, they may find that the return rate is low and that it impacts the team's plans. As a result, they may elect to shift to simply asking the Veteran what they want their health for during their check-in appointment as part of a conversation (vs. a form or check-the-box approach).



#### 8.7.6 Individuals Must Change for an Organization to Change

As noted earlier, it is critical that change management be addressed along with leadership support and project management needs when embarking on WHCC goals.

Example: When exploring the pilot team members' readiness for change, the supervisor may discover that some team members are not sure why change is necessary. Before proceeding with training (for example), the supervisor would take steps (in partnership with the Whole Health lead) to enhance awareness and desire. And if this can't be accomplished in a reasonable time, the supervisor may consider whether that team is appropriate to the pilot work, or whether the team may be better suited to take part in later efforts.

#### 8.7.7 Transformation Takes Time

With many successful program implementation efforts having been completed at a facility, it is common for staff to set ambitious timelines for their goals. As has been mentioned previously, however, Whole Health Clinical Care transformation is a cultural transformation in clinical practice and is NOT a new program. Therefore, this work can take substantially more time to accomplish (especially when change management is not addressed).

Example: For sites who set similar goals to the one shared in 8.7.1 above, some have initially started out with expecting 3-6 pilot teams to complete a PHI with 90% of their panel within a 3-6-month time period. This unrealistic time frame resulted in pilot teams becoming frustrated and in losing interest in practicing Whole Health. The consequences of this type of frustration can be long lasting and broad. It is better to set realistic goals within a reasonable time frame at the outset. Furthermore, ensure the teams are aware that "failure" to meet a goal within the expected time frame may merely signal that a change in approach may be needed (versus a "failure" of any of the team members).

#### 8.7.8 Aim for Change, not Checked Boxes

Using Whole Health in clinical practice is so much more than just checking a box. As overviewed above, it includes changing the conversation, connecting with purpose, building relationships, etc. But often, because tools like the PHI are concrete and many change efforts in clinical care have historically included new tools or reminders or "check boxes," we frequently see sites aiming to require completion of the PHI (or some other action) as an initial step. We encourage you to step back from the tool or perceived "boxes to check" and to consider the purpose behind what is being asked. A completed PHI can be part of using a Whole Health approach in Whole Health Clinical Care, *but does not equal Whole Health Clinical Care*. The same is true for CIH: it can be an important part of equipping Veterans to reach their goals, but it, too, does not equal Whole Health Clinical Care.

It is important to realize that both the PHI and CIH can be used in the existing paradigm *without a significant shift in practice occurring* (i.e., not connecting clinical recommendations or activities to MAP or using a tool in service of doing so). Rather than requiring the completion of the PHI, it may be prudent to have teams begin working on "changing the conversation" by starting with incorporating the "what matters most to you in your life" or similar question into their encounters.

Example: In example 8.7.1 above, perhaps the teams shifted from initially requiring the PHI to instead asking “what matters most” for new patients. The next goal may be for those teams to begin connecting their treatment recommendations to the Veteran’s MAP to lay the foundation for shared goal setting.

#### 8.7.9 Self-Care is Critical

Practicing WHCC is not only about providing care for Veterans, but also includes taking care of ourselves. Often, clinicians and clinical team members are so busy caring for others, there is little time or energy left to care for themselves. Integrating Whole Health into day-to-day operations at work and at home can have profound impacts. And, having the opportunity to experience some of the key tenets of Whole Health helps us speak to it more clearly with our colleagues, teams and Veterans.

Example: Teams (including facility and hospital leadership) can start each huddle with a moment of pause, take some deep breaths, or share an inspiring story. The facility may elect to incorporate Whole Health and the importance of employee Whole Health into New Employee Orientation.



*Myths #9: “This is just another VA initiative.”*

*Whole Health is a part of the VHA mission to deliver care in support of our Veterans’ health and well-being. It is a cultural transformation and not a program. Work has been ongoing for over 10 years with support from the highest levels of VA leadership and Congress.*

#### 8.8 Whole Health Clinical Care Additional Resources

**The delivery of Whole Health Clinical Care is not defined by what tool is used, but rather how the tool is used (if one is used) and for what purpose. The approach a clinical team will use with a Veteran will help to determine which tools the clinic will employ. If tools are being used in service of practicing Whole Health Clinical Care, then it is consistent with the Whole Health approach.**

There are several tools to aid in the implementation and delivery of Whole Health Clinical Care. They include both existing and newly developed tools. Unless otherwise indicated, the tools listed below can be found on the [OPCC&CT Communication Resources SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/sitepages/communication-resources.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/sitepages/communication-resources.aspx>):

- My Story PHI
- Brief PHI
- Review of the Circle of Health/Components of Health & Well-being
- [Healtheliving Assessment](https://www.myhealth.va.gov/mhv-portal-web/web/myhealthvet/healtheliving-assessment) (<https://www.myhealth.va.gov/mhv-portal-web/web/myhealthvet/healtheliving-assessment>)
- [Whole Health Integration with Primary Care and Mental Health SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/SitePages/WH_Integration_MH_PC.aspx) ([https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/SitePages/WH\\_Integration\\_MH\\_PC.aspx](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/SitePages/WH_Integration_MH_PC.aspx))

Many other materials are available to share or modify:

- Letters and/or brochures for Veterans with Whole Health language can be created. These can provide an opportunity for the team to craft a message to Veterans to set the tone for the new Whole Health clinical visit. This change is new to the Veteran and clinical team. Brochures for Veterans that outline the Whole Health approach are available free of charge from OPCC&CT. Visit the [Available Print Products page of the OPCC&CT SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/SitePages/Available-Print-Products.aspx) (https://dvagov.sharepoint.com/sites/VHAOPCC/SitePages/Available-Print-Products.aspx).
- Whole Health assessment tools include a mechanism to allow for Veteran self-reflection on their MAP, and around the Components of Health and Well-being. As noted and linked to above, the PHI is available for this purpose in the My Story PHI, PHI One-Pager, or PHI pocket card format. Some sites have modified the tools to include a clinical focus as well.
- [PHI and PHP CPRS templates and resources.](https://dvagov.sharepoint.com/sites/VHAOPCC/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x012000965D235B81AE9A40B070A146F202ECC1&viewid=4ba2c7d3%2Dd49a%2D456c%2Da49a%2Db6b2153c997b&id=%2Fsites%2FVHAOPCC%2FShared%20Documents%2FCIH%20Coding%20Guidance%2FNote%20Title%20Templates%2FNational%20Note%20Templates) (https://dvagov.sharepoint.com/sites/VHAOPCC/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x012000965D235B81AE9A40B070A146F202ECC1&viewid=4ba2c7d3%2Dd49a%2D456c%2Da49a%2Db6b2153c997b&id=%2Fsites%2FVHAOPCC%2FShared%20Documents%2FCIH%20Coding%20Guidance%2FNote%20Title%20Templates%2FNational%20Note%20Templates)
- Take-home note technology or after-visit reports can be developed to allow Veterans to have a copy of their PHP. This allows Veterans to have portions of the CPRS note printed in the clinical encounter, and for the team and Veteran to have the same goals and plan, supporting follow-up.
- Developing and maintaining a current list of CIH resources, both internal to the site and community based, and that is easily accessible for clinical teams to draw upon, makes incorporation of CIH modalities simpler.
- While Whole Health Clinical Care is an approach to care and not a “program,” there are some specific programs that have adopted a WHCC approach. The Whole Health Practice Committee (a team of leaders and clinicians serving across various VHA Program Offices, VISNs and facilities) reviews and vets such programs. Vetted clinical programs will be identified in the [list of Promising Practices on the Whole Health Innovations SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/SitePages/WH-Innovations.aspx) (https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/SitePages/WH-Innovations.aspx). If you are interested in submitting a program to the Whole Health Practice Subcommittee for review, please visit our [LEAF Whole Health portal](https://leaf.va.gov/NATIONAL/10NE/Whole_Health/) (https://leaf.va.gov/NATIONAL/10NE/Whole\_Health/) for more information and application instructions.

## References

<sup>1</sup>Coulter A, et al. Personalised care planning for adults with chronic or long-term health conditions: Cochrane Systematic Review 2015.

<sup>2</sup>Doyle C, et al. A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. BMJ Open 2013;3:e001570

<sup>3</sup>Simmons L, et al. Patient engagement as a risk factor in personalized health care: a systematic review of the literature on chronic disease. Genome medicine 2014.

<sup>4</sup>Bokhour, B, et al. Transforming the Veterans Affairs to a Whole Health System of Care, Medical Care: April 2020 - Volume 58 - Issue 4 - p 295-300 doi: 10.1097/MLR.0000000000001316

## **Resources**

[Whole Health Clinical Care Domain SharePoint Document Library](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WH_Clinical_Care_Domain/Forms/AllItems.aspx)

([https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WH\\_Clinical\\_Care\\_Domain/Forms/AllItems.aspx](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WH_Clinical_Care_Domain/Forms/AllItems.aspx))

## 9. Employee Whole Health Domain

This section about Employee Whole Health (EWH) has been developed to provide VISNs and facilities with information and tools to support effective implementation and integration of their Employee Whole Health programs and offerings. This *Guide* is intended to be used in combination with existing Employee Whole Health education and training, resources, online tools and support.

### 9.1 The Role of Employee Whole Health (EWH)

Implementation of the Whole Health System (WHS) represents a broad organizational and cultural transformation within VA. It provides an enormous opportunity not only for Veterans, but for employees as well, a substantial proportion of whom are Veterans themselves.

Early outcomes from Whole Health implementation suggest that employees who engage in a Whole Health approach to care feel more connected to their jobs and report less burnout and more job satisfaction. Refer to the [February 2020 Whole Health System Evaluation of Care Progress Report](https://www.va.gov/WHOLEHEALTH/docs/EPCCWholeHealthSystemofCareEvaluation-2020-02-18FINAL_508.pdf) ([https://www.va.gov/WHOLEHEALTH/docs/EPCCWholeHealthSystemofCareEvaluation-2020-02-18FINAL\\_508.pdf](https://www.va.gov/WHOLEHEALTH/docs/EPCCWholeHealthSystemofCareEvaluation-2020-02-18FINAL_508.pdf)) for the full report. Note that the final Flagship evaluation report, along with other related reports, will be housed on the [OPCC&CT Research & Evaluation SharePoint](https://www.va.gov/WHOLEHEALTH/professional-resources/clinician-tools/Evidence-Based-Research.asp) (<https://www.va.gov/WHOLEHEALTH/professional-resources/clinician-tools/Evidence-Based-Research.asp>).

**Cultural transformation in the VA will require a fundamental change in every employee, not only in how they interact with Veterans and perform their duties, but in their own personal experiences and how they live.** Because of this, the OPCC&CT has established Employee Whole Health as a crucial component of the Whole Health transformation strategy.

This is an important part of VHA's Modernization Effort to Transform HealthCare Delivery, and therefore building a strong Employee Whole Health foundation will set your institution up for success. For more information about this effort please visit the [VHA Modernization SharePoint](https://dvagov.sharepoint.com/sites/VACOVACOMPM/SitePages/ModernizationHome.aspx) (<https://dvagov.sharepoint.com/sites/VACOVACOMPM/SitePages/ModernizationHome.aspx>)

The vision of a fully transformed organization as it relates to the Employee Whole Health domain is that **the Whole Health approach will be the basis for VA employee-related policies, services and programs as it pertains to employee well-being**. This transformation will be guided by three strategic priorities:

1. Fostering a culture of collaboration and integration to promote EWH by leveraging and developing strategic partnerships across program offices and creating a multi-disciplinary committee and multi-disciplinary approaches at medical centers;
2. Providing employees at all locations convenient, ongoing access to resources/opportunities/tools/services to address and improve their overall health and well-being, reconnect with their own Mission, Aspiration, Purpose (MAP), and to experience Whole Health. This will be realized by system redesign to include EWH practices in the day-to-day workflows of employees in their services and departments; and
3. Establishing evidence of the value of Whole Health through its influence on employee satisfaction and engagement. Leaders will be able to easily speak to the value of investing in employee well-being based on relevant data and outcomes collected.

Finally, **employees will play a key role in promoting the Whole Health approach to Veterans and visitors** throughout the medical facility and community.

Please take a look at the six essential change management questions and our EWH strategy and tactics one-pager for more information to support your local implementation efforts. These documents are found on the [EWH Domain SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Employee_WH_Domain/Forms/AllItems.aspx) ([https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Employee\\_WH\\_Domain/Forms/AllItems.aspx](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Employee_WH_Domain/Forms/AllItems.aspx)).

### 9.1.2 Fostering a Culture of Collaboration and Integration to Promote Employee Whole Health

EWH supports the development of employee well-being initiatives that help employees live their best life in alignment with what matters most to the individual. Programs that support the components of health and well-being and healthy living messages such as stress management, quitting the use of tobacco, reaching and maintaining a healthy weight, eating healthier for their individual needs, becoming more physically active, and resting and recharging more effectively can help employees reduce their risk of chronic illness and optimize their health and well-being. Participation in self-care skill building classes such as yoga and tai chi, developing a meditation practice, or using guided imagery can increase employee resilience, potentially translating into lower sick leave usage, turnover, and burnout, and into higher productivity and job satisfaction.

It is recognized that many sites have long-standing well-being programs in place for employees. In addition, several program offices are often invested in providing these services to staff, such as Health Promotion Disease Prevention (HPDP), Chaplain Services, Occupational Health/Employee Health, Nutrition & Food Services, Office of Social Work Services, and many others. Strong collaboration with these other programs and offices is recommended to enhance the implementation of EWH.

**The following table describes additional collaborative partnerships in place at the national level that are specific to Employee Whole Health and can inform your strategy** for building supportive infrastructure at the facility level:

*Table 10: National Employee Whole Health Collaborative Partnerships*

<b>EWH Collaborative Partnership</b>	<b>Purpose</b>
<b>High Reliability Organization (HRO)</b>	Exploring potential synergies as they relate to mindful awareness/presence in work and employee resilience
<b>Veterans Experience Office (VEO)</b>	Exploring integration of Whole Health principles into employee trainings for ICARE and WECARE, as well as promotion of Own the Moment as fundamental skills in communication. Exploring further Whole Health integration in Journey Maps and Patient Experience University trainings for supervisors and front-line managers
<b>Office of Occupational Safety and Health</b>	Partnering to support employee wellness efforts, e.g. tobacco cessation and guidebook updates
<b>Veterans Benefits Administration (VBA)</b>	Providing Whole Health, such as mindfulness and stress management to VBA staff

EWH Collaborative Partnership	Purpose
VHA Human Resources (VHA HR)/Workforce Management and Consulting (WMC)	Collaborating on HR modernization efforts; Working closely on procedures for protected time for self-care
VA Human Resources (VA HR)/WorkLife and Benefits Service	Policy changes and provision of Employee Whole Health beyond VHA
National Center for Organization Development (NCOD)	Collaborating with the AES response team and leadership engagement/coaching teams to incorporate Whole Health principles into their approaches and offerings and encourage sites to utilize employee engagement resources
Diversity and Inclusion	Representing employee matters as they relate to diversity and inclusion on national committee(s)

## 9.2 Employee Whole Health Multi-Disciplinary Program Structure

### 9.2.1 Employee Whole Health/Well-being Coordinator

In order to provide opportunities for employees to experience Whole Health on an ongoing basis, **it is highly recommended that medical centers designate and train an Employee Whole Health/ Well-being coordinator.** The Employee Whole Health/Well-being coordinator is responsible for oversight of the Whole Health activities and programs that are created specifically for employees. Marketing, alignment with facility mission and goals, efficient and effective use of resources, and the overall success of employee Whole Health programs are under the auspices of this individual. The Employee Whole Health/Well-being coordinator also evaluates the impact of the program on employee well-being and engagement, and reports activities and outcomes to facility leadership. A national position description for the Employee Whole Health/Well-being coordinator has been written and classified and is available in the [Whole Health Positions folder on the HR Modernization SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WHHumanResources/Forms/AllItems.aspx?viewid=81726be2%2D9a7a%2D41d3%2D9af2%2D6c06f7dc0d21&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FWHHumanResources%2FWH%5FPositions) (<https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WHHumanResources/Forms/AllItems.aspx?viewid=81726be2%2D9a7a%2D41d3%2D9af2%2D6c06f7dc0d21&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FWHHumanResources%2FWH%5FPositions>).

### 9.2.2 Employee Whole Health Committee

The Employee Whole Health/Well-being coordinator should establish and chair or co-chair the Employee Whole Health Committee, a diverse planning team of interdisciplinary health professionals and representatives from various services within the medical center, including labor partners. The Employee Whole Health Committee is a facility-level group that plans and implements employee programming. The committee should factor hospital, VISN, VHA, and VA goals, needs assessment, data analysis for the population, evidenced-based interventions, and the resources available into its planning. The committee should develop a charter, and may also develop its own strategic plan to determine short and long-term goals and objectives to effectively promote health throughout the facility. [Sample EWH committee charters](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Employee_WH_Domain/Forms/AllItems.aspx?viewid=06077045%2Ddbf7%2D4e20%2D) ([https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Employee\\_WH\\_Domain/Forms/AllItems.aspx?viewid=06077045%2Ddbf7%2D4e20%2D](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Employee_WH_Domain/Forms/AllItems.aspx?viewid=06077045%2Ddbf7%2D4e20%2D)



b288%2D0ef80be938f2&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FEmployee%5FWH%5FDomain%2FCharters%5FEWH) are available on the EWH Domain SharePoint.

Committee members can be selected based on area of expertise or as representatives from various work areas of the organization. To advance EWH, it is advisable to include Subject Matter Experts from each of the eight areas of self-care that comprise the Circle of Health as committee members or ad hoc members in order to ensure integration into diverse service lines. Committee members should have a commitment to Employee Whole Health, and be willing to devote time to building and implementing the program. Members should also be responsible for communicating related activities throughout the facility and receiving feedback from employees.

The EWH/Well-being coordinator and EWH Committee should work to foster collaboration across services lines and departments. A key partnership to consider includes working with the local Employee Assistance Program (EAP). Integrating the Whole Health system of care into existing EAP processes will ensure we are helping employees in a personalized, proactive method, curtailing escalated needs for more emergent assistance downstream. For example, to provide support for job and/or emotional stress, an employee may be encouraged to participate in a meditation class offered as part of local Employee Whole Health programming when they seek assistance through EAP. Other key partnerships to foster collaboration include working with the local Organizational Health Council if present, Occupational or Employee Health, Patient Safety and Quality, as well as System Redesign. Working to guide local System Redesign efforts will be very important in helping realize transformational goals as we work to integrate Employee Whole Health practices into the day-to-day workflows of employees in their services and departments.

### 9.2.3 Perform a Needs Assessment

The most successful employee well-being programs are those that are individualized for the needs of the population. A needs assessment is a crucial first step to take to determine what your Employee Whole Health program will look like, and what components will have the greatest impact.

Needs assessments can take multiple forms. A needs assessment can include a health screening with biometric or laboratory results to get a snapshot of the health needs of the population. In the context of Employee Whole Health, more often a needs assessment is a questionnaire intended to determine staff interests and preferences surrounding health and well-being offerings and approaches. While health screening results may indicate one need and the questionnaire a different health concern, it is equally important to address both. For instance, it may be determined that, although a high percentage of employees are overweight or obese, their greatest concerns according to the needs assessment may be stress management, work-life balance, and options to incorporate meditation and other complementary and integrative health (CIH) services into their workday. In this example, it would be imperative to develop a program that addresses *all* of the identified needs.

Needs assessments should be anonymous to both protect the employee and to ensure the most honest feedback. Every attempt should be made to reach the broadest cross section of the workforce as possible. [Sample needs assessment questionnaire/wellness surveys](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Employee_WH_Domain/Forms/AllItems.aspx?viewid=06077045%2Ddbf7%2D4e20%2Db288%2D0ef80be938f2&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FEmployee%5FWH%5FDomain%2FCharters%5FEWH) (https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Employee\_WH\_Domain/Forms/AllItems.aspx?viewid=06077045%2Ddbf7%2D4e20%2Db288%2D0ef80be938f2&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FEmployee%5FWH%5FDomain%2FCharters%5FEWH)

FDomain%2FNeeds%5FAssessment%5FEWH) can be found on the Employee Whole Health Domain SharePoint.

An evaluation of institution-specific needs can aid in the development of strategic goals and provide the baseline for both outcome evaluation and feedback, leading to program improvement. An environmental scan or gap analysis can identify existing institutional values and current employee Whole Health offerings, as well as Well-being programs. Completion of a gap analysis will facilitate discussions about institutional needs and resources. A [sample EWH gap analysis](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Employee_WH_Domain/Forms/AllItems.aspx?viewid=06077045%2Ddbf7%2D4e20%2Db288%2D0ef80be938f2&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FEmployee%5FWH%5FDomain%2FNeeds%5FAssessment%5FEWH) (https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Employee\_WH\_Domain/Forms/AllItems.aspx?viewid=06077045%2Ddbf7%2D4e20%2Db288%2D0ef80be938f2&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FEmployee%5FWH%5FDomain%2FNeeds%5FAssessment%5FEWH) is also available on the Employee Whole Health Domain SharePoint.

Results of the environmental scan or gap analysis will aid in recruiting support and commitment from senior management, both of which are crucial to program success. Front-line and Senior management play a critical role in organizational culture. Leadership can support the program by approving the availability of time, space, and staff, and by serving as role models. It is recommended that you take some time to identify those champions and influential leaders at your facility.

#### 9.2.4 Develop a Plan

Based on the results of the needs assessment, you are now ready to establish a plan for your Employee Whole Health program. Appropriate planning will save resources and aid in creating a more effective program. An Employee Whole Health Committee which includes pertinent stakeholders and influential leaders should participate in the planning process. It is important to first consider the organization's mission and priorities. The committee should then determine its overall mission for the Employee Whole Health program. The mission should support the Veterans Health Administration's (VHA's) overall mission and the Department-level strategic goals as described in [VA's 2018-2024 Strategic Plan](https://www.va.gov/oei/docs/va2018-2024strategicplan.pdf) (https://www.va.gov/oei/docs/va2018-2024strategicplan.pdf).

For example, VA Strategic Plan Management Objective 4.2 states that "VA will modernize its human capital management capabilities to empower and enable a diverse, fully staffed, and highly skilled workforce that consistently delivers world-class services to Veterans and their families." The accompanying performance goals seek to attract and retain a quality workforce by being identified as "one of the best places to work in the Federal Government." **Examples of EWH program mission statements in support of these goals could be one or more of the following:**

- Providing a personalized Whole Health experience for every employee
- Maximizing the health and well-being of the employee population
- Improving retention, recruitment, and productivity of employees
- Offering a multi-faceted program for educating employees on Whole Health approaches and behaviors

Once the EWH mission is determined, it will be possible to establish key goals. When thinking strategically, key goals will include short (tactical/1 year), long-term (strategic/2 to 5 year), and transformational (5-10 year) goals. Keeping goals broad, but limited in number, will help to maintain

focus while also allowing for adjustments over time. **Examples of some tactical goals and deliverables relevant to Employee Whole Health are listed below:**

- Offer *Whole Health 102* for employees quarterly
- Host (x number of) employee retreats (face-to-face or virtually) with evaluation of resiliency pre-post
- Conduct *Taking Charge of My Life and Health* for employees with running cohorts throughout the year
- Offer individual Whole Health coaching for employees
- Foster collaboration with the Employee Assistance Program (EAP)
- Foster collaboration with Employee Occupational Health (EOH)
- Merge employee well-being and employee Whole Health efforts; revise committee charter
- Offer programming such as VA2K, mindfulness, CIH for well-being

Taking time to make a strategic plan can go miles in creating a smoother implementation process. The needs assessment and environmental scan, along with the committee mission statement and broader goals, will be immensely helpful in drafting this plan. Equally important is the ability to look at existing strengths, weaknesses, threats, and opportunities that will inform strategic thinking and ultimately tactical/operational plans. This plan will likely support the larger Whole Health implementation plan for a facility.

Another key step in planning may be to create a more formal business plan. A business plan is a written document that provides justification for committing resources to a new project. It includes a description of the problem or opportunity, the costs and benefits of several alternative solutions, a summary, and a recommended solution for approval.

The business plan is used as a reference during the project's life cycle to determine if the project is on track for completion within the time, cost, and scope outlined. At the end of the project, the business plan is used to measure project success by its ability to meet the goals and objectives defined in the plan. Goals often focus on the impact that the project will make on the organizational mission.

Plan components include the project background, expected organizational benefits, possible options (including maintaining status quo), pros and cons (costs and risks of each option), the expected project costs, a gap analysis, and the expected risks. As the program is developed, the business case can be reviewed and adjusted as needed to reflect changing organizational requirements.

A general overall approach to planning might include a strategic plan which incorporates the *Designation Framework*, a tactical/operations plan with the goals/deliverables, and then ideally, a business plan that supported the case for FTE/resources to do the work. This plan should be a part of the overall Whole Health System Strategic Plan and incorporated into the facility strategic plan for optimal success.

#### 9.2.5 Implement the Employee Whole Health Plan

If planning is given sufficient attention, implementation can be more effective. There should be clear objectives stated for each goal from your strategic plan. Determining objectives and timelines, responsible parties, and measurable goals along with a clear communications plan ensures successful implementation. The plan will likely be revised over time following feedback from stakeholders.

A successful launch provides initial momentum for the program. A launch could be a hard launch or soft launch. A hard launch is usually in the form of a large singular event such as a health fair or other kick-off event. A soft launch may be a series of events or promotions leading up to a kick-off event. Examples include a contest, a series of health tips, or mini-challenges that work to create excitement for the kick-off.

Good marketing of the launch event is essential in getting participation and developing program awareness. One of the key concepts to consider is program branding. The American Marketing Association defines a brand as a "name, term, sign, symbol, or design, or a combination of them, intended to identify the goods and services of one seller or group of sellers and to differentiate them from those of other sellers." Program branding provides an identity to reach the target market (employee population). The brand may represent the mission, goals, or overall program content.

**Implementation does not end with the kick-off event. This is just the beginning in cultural transformation!** Ongoing communications and educational strategy, as well as promotion of the programs and resources available to employees will also be necessary to encourage participation. The focus should continually be on integration of employee Whole Health principles into the day to day functions of VHA, and promotion of transformation of healthcare delivery to a Whole Health System.

#### 9.2.6 Communications and Marketing

To maximize and drive participation in your Employee Whole Health program, you need to deliver regular communication and marketing of Whole Health to all staff using a variety of multimedia approaches. Successful marketing is built on a foundation of trust. Using marketing tools to create an image that is superficial will not achieve long-lasting goals. Effective marketing is grounded in the employee's perspective. Additionally, close attention to social determinants of health and inclusion of diversity is very important in a marketing strategy. For instance, a weight reduction program should not be marketed as a way to increase energy for maximum productivity.

The end user or the consumer of this product is the employee, and a group of consumers (employees) is the market. Characteristics of the market are considered at every stage in the marketing process, including the initial development of the product.

Various channels should be used to advertise your Employee Whole Health program. Channels are communication paths to our target audiences. Channels available for employee communication may include:

- Facility Intranet
- All Employee Newsletter
- Face to Face
- Digital Displays
- All Employee Emails
- Facility Facebook
- Newsletter from EWH office
- Service or departmental meetings with information provided by supervisors

### 9.2.7 Evaluate the Employee Whole Health Plan

Evaluation is an essential part of planning and quality improvement. Evaluation is a systematic process to understand what a program does and how well the program does it. Evaluation results can be used to maintain or improve program quality and to ensure that future planning can be more evidence-based. Evaluation constitutes part of an ongoing cycle of program planning, implementation, and improvement.

Ongoing data review and program evaluation facilitate the revision of existing programs and materials, and will ensure innovation and continuous interest in the program. More information on evaluation can be found in section [11. Evaluating Whole Health Implementation](#) of this *Guide*.

### 9.2.8 Sustain the Employee Whole Health Plan or Program

Program sustainability involves being able to extend a program beyond its implementation cycle or beyond the end of its initial funding period. Sustainability depends on continued relevance to the organization, key stakeholders, and the capacity to achieve intended outcomes. This is where a well thought out strategic plan, evaluation plan, and business plan can be helpful as checkpoints for your work thus far and evidence of need to continue forward or even expand efforts. Even an effective prevention program will have limited impact if it is not sustained. Program sustainability helps assure that the needs of a changing workforce are met. It is critical to plan for sustainability early in the planning and implementation process.

#### **Critical elements for sustainability include:**

- The Employee Whole Health Program is aligned with the organization's mission, vision, and values and VHA's strategic priorities, goals and objectives
- Facility EWH goals and objectives are clearly defined and achievable
- The program is results-oriented
- Qualitative and quantitative outcomes are tracked and evaluated in order to demonstrate effectiveness
- Resources are used efficiently (business plan)
- Effective communication and collaboration with stakeholders (including all program participants, partners, and leadership) is established and maintained
- Program is adapted to changing conditions (ongoing method for employee and leadership feedback)

## 9.3 Providing the Whole Health Experience to All Employees

### 9.3.1 Practice Redesign

Practice redesign involves integrating Employee Whole Health practices into the day-to-day workflows of employees in their services and departments. It can include something as simple as incorporating mindfulness exercises or mindful moments into team meetings or something more complex such as allowing employees the opportunity to share their work experiences and stories in a meaningful way (e.g. employee story-telling) or incorporating self-reflection and debriefing into normal business operations.

Practice redesign also involves providing employees the time to participate in Employee Whole Health activities. To that end, the following guidance has been developed. In collaboration with the VA WorkLife and Benefits Service, VHA Workforce Management and Consulting, and Office of General Counsel, Employee Whole Health has outlined current **time and leave mechanisms that exist for employees to participate in designated self-care and well-being activities on duty time. These include the following:**

1. Integration of Employee Whole Health education on self-care and resiliency into existing employee trainings including but not limited to New Employee Orientation (NEO) and training for new supervisors
2. Use of flexible work schedules (FWS) to permit recurring participation in designated EWH self-care and well-being activities
3. Use of employee assistance program (EAP) for short-term self-care support needs that may include recommended participation in EWH self-care and well-being activities
4. Use of administrative leave/excused absence for intermittent health and well-being events, such as health fairs, the VA2K, or EWH retreats as approved by the medical center director (MCD)

An [Employee Participation in Designated Self-Care and Wellness Activities fact sheet](https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/EWH/Shared%20Documents/Employee_Time_for_Participation_in_Self-Care_Activities.docx?d=w79d877f87c714481a7a8a4f27abe8250&csf=1&web=1&e=aU9IM6)

([https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/EWH/Shared%20Documents/Employee\\_Time\\_for\\_Participation\\_in\\_Self-](https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/EWH/Shared%20Documents/Employee_Time_for_Participation_in_Self-Care_Activities.docx?d=w79d877f87c714481a7a8a4f27abe8250&csf=1&web=1&e=aU9IM6)

[Care\\_Activities.docx?d=w79d877f87c714481a7a8a4f27abe8250&csf=1&web=1&e=aU9IM6](https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/EWH/Shared%20Documents/Employee_Time_for_Participation_in_Self-Care_Activities.docx?d=w79d877f87c714481a7a8a4f27abe8250&csf=1&web=1&e=aU9IM6)) outlining current options is posted on the Employee Whole Health SharePoint hub.

Other opportunities for practice redesign involve local participation by employees in peer leader training to become self-care champions.

### 9.3.2 Peer Leaders

#### **What is a peer leader?**

An employee peer leader serves as a self-care champion for co-workers. The peer leader provides information, encouragement and tools while acting as a role model to help others practice self-care skills. A peer leader is a mentor who has learned to successfully guide their colleagues through Whole Health experiences so that they can reach wellness goals. Employee peer leaders support Employee Whole Health coordinators and committees, enabling them to reach more employees and provide more services. As self-care champions, they are the drivers for building a culture of health and encouraging participation by their fellow employees.

#### **The Peer Leader is:**

1. Engaged in self-care and well-being activities
2. Empathetic to the issues that employees experience as they attempt to practice Whole Health and make positive lifestyle changes
3. Dedicated to helping their fellow employees achieve their self-care and well-being goals
4. A model of a healthy lifestyle

#### **The role of a Peer Leader:**

- Serves as a member of the facility Employee Whole Health committee
- Acts as a champion for self-care and well-being activities

- Serves as a role model to employees
- Contributes to the development of a culture of health and well-being
- Supplements the Employee Whole Health coordinator
- May act as the Employee Whole Health point of contact in smaller sites
- Confers with Employee Whole Health coordinator for issues that are outside of peer leader boundaries
- Engages, establishes rapport, and demonstrates empathy in a non-judgmental manner to fellow employees
- Serves as a volunteer to assist in the implementation and coordination of self-care and well-being initiatives at their location
- Shares information, engages friends and colleagues to participate in wellness programs and creates excitement around practicing Whole Health

**A Peer Leader does not:**

- Provide clinical care, therapy or treatment to employees

Finally, many practice redesign efforts at local medical centers can be supported by taking advantage of the funding opportunities provided by the Office of Patient Centered Care & Cultural Transformation.

## 9.4 Providing Opportunities for Education, Training and Experientials

### 9.4.1 Whole Health 102: Whole Health for You and Me

A key component of any Employee Whole Health program should include an introduction to the main principles and concepts of the Whole Health System. This can be accomplished by hosting OPCC&CT's Whole Health 102 course.

Whole Health for You and Me (WH102) is a 4-hour experience designed to guide participants in exploring Whole Health and considering how it can be used to improve one's own health and well-being. This experiential training is accredited and can be offered either in a 4-hour block or as 1-hour modules. The goal of this program is to help each employee identify their mission, aspiration, and purpose, and understand how they can make changes in their lives to help them work towards achieving their personal goals. During the course, employees learn why the VA has adopted a Whole Health approach to health care, review the Circle of Health to see how it provides guidance for making changes in one's life, and learn about local resources—including Employee Health and well-being—that support improved health. At the conclusion of this program, each employee will have the opportunity to identify areas of growth and develop a plan to strive towards their goals. This course is geared toward all VA employees who have not previously attended a Whole Health course. More information on this course including course presentation materials, agenda, and TMS brochure are located on the [Whole Health Education OPCC&CT SharePoint site](https://dvagov.sharepoint.com/sites/VHAOPCC/Education/Whole%20Health%20for%20Employees/Forms/AllItems.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/Education/Whole%20Health%20for%20Employees/Forms/AllItems.aspx>).

The goal within each medical center should include offering WH102 on an ongoing basis, such as monthly or quarterly, in order to have as many employees take part as possible. Another important strategy to consider is the inclusion of introductory content on the main principles and concepts of the Whole Health System in New Employee Orientation (NEO). It is recommended that this content include



a review of the Circle of Health to see how it provides guidance for making changes in one's life, as well as information on local resources to support Employee Whole Health available at the medical center.

#### 9.4.2 Employee Whole Health: TCMLH and Resiliency Focused TCMLH for Employees

The Employee Whole Health Pathway is built upon healing relationships with clinical and non-clinical staff who have been trained to help fellow staff (re)discover their MAP. The Pathway consists of individual and group sessions that begin with the practice of mindful awareness as a way to pay attention on purpose. Employees self-reflect on their MAP and begin their overarching PHP. The Pathway utilizes methods of teaching and experiencing CIH approaches to self-care. The Employee Whole Health Pathway encourages staff to take charge of their life and health as they consider the Components of Proactive Health and Well-being:

1. Moving the Body – exercise and movement for energy, flexibility, and strength
2. Surroundings– how things around you affect your body and emotions
3. Personal Development – learning and growing throughout your lifetime
4. Food & Drink – nourishing your body
5. Recharge – sleep, rest, relaxation
6. Family, Friends, & Co-workers – your relationships with others
7. Spirit & Soul – a sense of connection, purpose, and meaning
8. Power of the Mind – tapping into your ability to heal and cope

Two Employee Whole Health group-based programs are available. One way for employees to learn about Whole Health is to take part in Employee Whole Health Pathway activities including participation in a *Taking Charge of My Life and Health (TCMLH) for Employees* program, *Resiliency Focused TCMLH for Employees* and/or using the *Live Whole Health app* to further their health and well-being.

*TCMLH* is a 9-week peer-led group-based program designed to assist in:

- Exploring one's life mission, aspiration, and purpose
- Learning the practice of mindful awareness
- Goal setting, skill-building, and self-management of one's health and health care
- Support in a group setting through the process of change

*Resiliency Focused TCMLH for Employees* is an 8-week peer-led group-based program.

Employees in healthcare settings are frequently more vulnerable to empathy-based stress or fatigue as a result of repeated exposure to secondhand trauma and fear of loss. *Resiliency Focused TCMLH for Employees* features strategies and tools designed to counter empathy-based stress and build employee resilience. A critical part of the VA's Whole Health cultural transformation is how we, as VA employees, address our own self-care and well-being. We've included familiar Whole Health activities, such as reflecting on your mission and purpose, and integrated specific exercises to counter empathy-based stress, including strengthening social relationships, creating more balance in your life, and being more aware of how you may be feeling.

Employees are encouraged to download the [Live Whole Health app](https://mobile.va.gov/app/live-whole-health) (<https://mobile.va.gov/app/live-whole-health>) to further their health journey. Through the app, employees can walk through the Personal Health Inventory and set health and well-being goals based on what matters most to them. The app is currently available for Apple and Android devices in the Apple and Google Play stores.

### 9.4.3 Whole Health Skill-Building Courses

Once employees have completed WH102 a logical next step is to offer the Whole Health Skill-Building Courses to give employees additional content related to each of the eight components of the Circle of Health. While originally designed for Veteran audiences, the content of the skill-building courses is applicable to employees as well. It is assumed that employees have already been introduced to key Whole Health concepts before they take any of these courses. That is, they have heard in general about what Whole Health is and they have completed a Personal Health Inventory (PHI) and begun to think about topics they would like to include in their Personal Health Plan (PHP).

All of the skill-building courses share the following key elements:

- Each course includes about 15-20 minutes of lecture material from PowerPoint slide presentations. Otherwise, the PowerPoint slides are used to facilitate discussions or guide experiential learning
- Each course includes 15-30 minutes of large and small group discussion
- Each course also includes a 5-10 minute mindful awareness script, written specifically for that self-care topic. A course instructor can read the script during the course
- Courses also feature a demonstration, ideally offered by a colleague from the local VA with special interest in a particular area of self-care. For example, this may include a chaplain for the Spirit & Soul course, a psychologist for Power of the Mind, or a dietitian for Food & Drink. These experts have the opportunity to demonstrate a skill or technique and can help with other parts of the course, too, as appropriate
- Finally, each course includes a 15-minute goal setting opportunity, during which employees can pair up and take turns outlining their own goal related to the particular area of self-care

Course elements should be modified to fit time allowed for employee participation. Oftentimes, employees can take only 30 minutes over the lunch break to participate in a course of this type. Course content may need to be condensed or offered over multiple weeks to accommodate the work schedules of employees. More information on the skill-building courses can be found on the [Circle of Health section of the EWH SharePoint site](https://dvagov.sharepoint.com/sites/VHAOPCC/EPH/SitePages/Circle-of-Health.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/EPH/SitePages/Circle-of-Health.aspx>) or on the [OPCC&CT Education SharePoint site](https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Whole%20Health%20Skill%20Building.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Whole%20Health%20Skill%20Building.aspx>).

### 9.4.4 Whole Health Coaching for Employees

Health and well-being coaching is commonly used to help people meet their personal health and well-being goals. Employee Whole Health coaches help employees reach health goals that are based on the employee's own life mission, aspiration and purpose. The belief is that changes in health habits are sustainable when linked to personal values and sense of purpose.

The coach does more than provide information, because even expert advice is not enough to bring lasting behavior change for many who are struggling with health, wellness and fitness issues. Most people know when they are stressed, that smoking is bad for their health, that they don't get enough

sleep, that they are eating poorly, or that they are insufficiently active. Since the consequences of poor health behaviors are not immediately felt, habits practiced for a long time may be too difficult for an individual to change without support.

Health coaching incorporates skills in motivational interviewing, expertise in health, wellness, and fitness along with knowledge of psychosocial issues to empower individuals and support behavioral change. Participants work with their coach in a series of consultations in order to develop, foster, and support individual risk and disease management. Together, coach and employee decide on goals and build an individualized program to change health-related behaviors.

During the first visit, the coach should ask the employee about their mission aspiration and purpose (MAP) to gain an understanding of the employee's intent, motivation, and level of commitment. The MAP, along with the employee's PHI, will facilitate the development of goals and an understanding of the barriers faced by the employee in meeting those goals. The coach helps the individual navigate through different stages of change by creating awareness of inhibiting patterns of behavior and uncovering strengths, resources and opportunities for their clients.

Health behavior changes are preventive in nature (e.g., weight management, smoking cessation, stress management). Employee Whole Health coaching is not intended as therapy or treatment, and the coach does not provide clinical services. It is important that the coach recognizes signs and symptoms of depression, suicide, abuse, and other psychosocial problems and refers employees to licensed and trained clinicians if necessary. Every VHA facility should have an Employee Assistance Program (EAP). EAP services are free to employees, and staff members are trained to deal with acute and chronic psychosocial problems. Individuals presenting with psychosocial problems should be encouraged to seek assistance with the facility EAP, and coaches should assist them in making appointments to assure they receive appropriate and timely care. Individuals with medical conditions should be referred to their primary care provider.

It is important for coaches to have a strong knowledge base in the principles of coaching and health behavior change. The OPCC&CT offers VHA Whole Health Coaching Foundations Training. Details about this training can be found on the [OPCC&CT Education SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Whole-Health-Coaching.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/Education/SitePages/Whole-Health-Coaching.aspx>). Employees participating in Whole Health coaching have reported significant reductions in perceptions of stress, increased resiliency, and fewer days of poor mental health in pre-post comparisons.

## 9.5 Employee Whole Health Well-being Programs

Employee Whole Health Well-being programs focus on equipping employees with self-care, skill building, and support to actively attain and sustain a personal and organizational culture of health and well-being that embodies the values of VA to inspire Veterans and the community to live their fullest lives. Employees can develop a PHP to best meet their goals in alignment with their MAP. Well-being programs are not diagnosis or disease based, but rather support the personal health plan of individuals and equip employees to achieve their goals and what matters most to them. Well-being services build on and incorporate the existing health education and health promotion programs developed specifically for employees, including lifestyle, nutrition and healthy eating, tobacco cessation, and stress management. The EWH SharePoint site provides tools and materials to help you establish effective programs. It also provides convenient, ongoing access for all VA employees to resources/

opportunities/tools/services specifically written for employees, to address and improve overall health and well-being. Please review the [EWH SharePoint site](https://dvagov.sharepoint.com/sites/VHAOPCC/EWH/SitePages/Home.aspx) (<https://dvagov.sharepoint.com/sites/VHAOPCC/EWH/SitePages/Home.aspx>) to understand the tools and resources available to you.

**Examples of Employee Whole Health Well-being programs may include** (those in bold are core offerings that will be expanded on further):

- Education for health literacy/prevention and self-care
  - **Lifestyle nutrition and healthy eating**
  - **Tobacco cessation**
- Movement classes
  - **Moving the body**
  - Yoga
  - Tai chi
  - Aerobics/fitness/**physical exercise**
- Stress management
  - **Creating Balance**
  - Meditation/mindfulness
  - Guided imagery
  - Relaxation classes
  - Self-care massage

The following Employee Whole Health core programs have been designed and evaluated for use by EWH program coordinators. Program coordinators can utilize these programs within a supportive environment to provide knowledge, skills and opportunities to empower employees to make lifestyle changes that can improve their overall health.

#### 9.5.1 Quitting Tobacco with Whole Health

*Quitting Tobacco with Whole Health* provides the format, tools and coaching strategies necessary for EWH Coordinators to set up a validated tobacco cessation program. There is also “on demand” information and support for employees wishing to quit the use of tobacco available in a new self-directed podcast series. This series is available to employees on the Talent Management System TMS COURSE: [Whole Health for Employee Tobacco Cessation-TMS ID 43874](https://va-hcm03.ns2cloud.com/learning/user/deeplink.do?OWASP_CSRFTOKEN=TTWO-I03J-3ERY-Y37Z-80UH-S7H1-TZ65-O9RL&linkId=ITEM_DETAILS&componentID=43874&componentTypeID=VA&fromSF=Y&revisionDate=1613156580000) ([https://va-hcm03.ns2cloud.com/learning/user/deeplink.do?OWASP\\_CSRFTOKEN=TTWO-I03J-3ERY-Y37Z-80UH-S7H1-TZ65-O9RL&linkId=ITEM\\_DETAILS&componentID=43874&componentTypeID=VA&fromSF=Y&revisionDate=1613156580000](https://va-hcm03.ns2cloud.com/learning/user/deeplink.do?OWASP_CSRFTOKEN=TTWO-I03J-3ERY-Y37Z-80UH-S7H1-TZ65-O9RL&linkId=ITEM_DETAILS&componentID=43874&componentTypeID=VA&fromSF=Y&revisionDate=1613156580000))

It is also available through VHA Podcast on Spreaker: [Whole Health for Employee Tobacco Cessation: Veterans Health Administration](https://www.spreaker.com/show/whole-health-for-employee-tobacco-cessat) (<https://www.spreaker.com/show/whole-health-for-employee-tobacco-cessat>).

A complete list of this podcast featured on multiple platforms can be found in the EWH SharePoint document [Tobacco Cessation Podcast](https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/EWH/Quitting-) (<https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/EWH/Quitting->

Tobacco/\_layouts/15/Doc.aspx?sourcedoc=%7B5061E9FB-A001-4561-B912-424ACF95EB38%7D&file=Tobacco\_Cessation\_Podcast.docx&action=default&mobileredirect=true).

Using VA's Whole Health approach, program facilitators help participants tap into the source of their motivation to make behavioral changes by helping them explore and identify their mission, aspiration and purpose in life – or what really matters to them. Another key aspect of Whole Health is mindful awareness. Participants learn to become more conscious smokers – paying attention to their internal and external triggers for smoking as well as to the actual experience of smoking. Participants will start out exploring their mission, aspiration and purpose, along with their reasons for wanting to quit. They learn what it means to become a conscious smoker; to recognize some of the reasons, or triggers, that might make them reach for a cigarette throughout the day, and also pay attention to the actual experience of smoking. Along with support through counseling, nicotine replacement therapy (NRT) plays an important role giving participants the best chance for success.

Refer to the [Quitting Tobacco section of the Employee Whole Health SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/EWH/Quitting-Tobacco) (https://dvagov.sharepoint.com/sites/VHAOPCC/EWH/Quitting-Tobacco) for further information about this program.

### 9.5.2 Creating Balance with Employee Whole Health

*Creating Balance with Employee Whole Health* provides the format and tools for facility EWH coordinators to set up a stress management program. It also contains practical tools, such as mindfulness, yoga, tai chi and other stress management techniques that employees can access on demand. These resources empower employees to harness the power of their mind to improve their health and well-being.

Stress is a normal part of life. In small quantities, stress is good -- it can motivate people and help them be more productive. However, too much stress, or a strong response to stress can set individuals up for adverse health events. Identifying stressors and learning how to manage stress through exercise, diet, social support, and relaxation are steps individuals can take to reduce the stress in their lives.

This EWH program helps employees understand and recognize their stressors, foster resilience and cultivate positive messages. Tools include problem solving skills and self-care activities that can be used to develop a personal resiliency plan in the face of change or disruption. Self-care activities include meditation, guided imagery, relaxation breathing and other mindfulness-based tools to build resiliency and increase well-being.

Refer to the [Power of the Mind section of the Employee Whole Health SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/EWH/Power-of-the-Mind) (https://dvagov.sharepoint.com/sites/VHAOPCC/EWH/Power-of-the-Mind) for further information about the Creating Balance in-person and virtual programs.

### 9.5.3 Employee Whole Health Lifestyle Nutrition

*Employee Whole Health Lifestyle Nutrition* provides program materials for EWH coordinators to implement a Whole Health nutrition program for employees. The program goal is to prevent and control obesity and other chronic diseases through healthful eating and physical activity. It also contains practical tools about healthy eating that employees can access on demand.

The rapidly rising rate of obesity is a growing concern in America. According to the Centers for Disease Control and Prevention, the obesity rate reached 42.4% in 2017-2018. Obesity is a serious concern because it is associated with poorer mental health outcomes, reduced quality of life, and the leading causes of death in the U.S. and worldwide, including diabetes, heart disease, stroke, and some types of cancer.

The program format of *Employee Whole Health Lifestyle Nutrition* is based on the Dietary Guidelines for Americans, enabling facilitators to help employees improve their overall eating patterns to decrease their risk of chronic diseases. Participants learn about food labels, portion control and how to replace energy-dense, nutrient-poor foods with nutrition rich food that will nourish their bodies. The program focuses on having positive thoughts associated with food, to increase energy, and stay healthy. Making healthy choices about what you eat and drink is a powerful way to help care for yourself.

Refer to the [Food and Drink section of the Employee Whole Health SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/EWH/Food-and-Drink) (<https://dvagov.sharepoint.com/sites/VHAOPCC/EWH/Food-and-Drink>) for further information about in-person and virtual nutrition programs for employees.

#### 9.5.4 Moving the Body

*Moving the Body* provides materials and tools that all employees can utilize at home or at work in order to achieve the recommended levels of physical activity. It also offers materials EWH Coordinators can use to plan fitness activities for staff. Regular physical activity is one of the most important things a person can do for their health. Important physiological and psychological benefits include improving brain health, managing weight, reducing disease, strengthening bones and muscles, and improving one's ability to perform everyday activities. The Physical Activity Guidelines for Americans recommend that adults get at least 150 minutes of moderate-intensity aerobic physical activity or 75 minutes of vigorous-intensity physical activity, or an equivalent combination each week. Incorporating flexibility, balance and strength training of all major muscle groups 2-3 times a week are also recommended.

##### *9.5.4.1 Options to increase physical activity (e.g., employee fitness centers, group exercise classes, walking groups) and environmental supports (gym, bike racks, walking paths)*

The Office of Personnel Management (OPM) encourages all agencies to establish and administer physical fitness programs as an integral component of their employee health services program. [Chapter 2 of the OPM Employee Health Services Handbook](https://www.opm.gov/policy-data-oversight/worklife/reference-materials/employee-health-services-handbook/#url=Chapter-2) (<https://www.opm.gov/policy-data-oversight/worklife/reference-materials/employee-health-services-handbook/#url=Chapter-2>) discusses fitness center funding such as collecting fees from employees, as well as the use of excused absence to encourage health and fitness activities. According to OPM, examples of situations that may warrant short periods of excused absence include participation in officially-sponsored and administered physical fitness programs, health education classes, medical screenings, or health fairs.

In addition to programs and facilities, agencies can promote active lifestyles through policies and environments. OPM lists the provision of showers, locker rooms, bike racks, running maps, and operation of on-site fitness facilities as examples of services that can be provided. In the case of size or space limitations, agencies can offer fitness activities without special facilities.

There are many opportunities for physical activity that can be explored. An employee questionnaire can indicate preference and program content. In addition to employee interest, consider available resources

such as space. If space is severely limited, a fitness center may not be feasible. Programs should be structured to meet the needs of employees on all shifts, at all fitness levels, and to accommodate people with differing needs.

There are numerous types of programs for incorporating exercise into the worksite. Examples include:

- Walking programs utilizing outdoor and indoor walking paths and encouraging use of stairwells
- Desk exercises and stretches
- Instructor-led programs such as aerobic fitness, strength training, yoga, stretching
- Biking; promoted through availability of bike racks, sharing programs and team events
- Team sports such as basketball or baseball
- Fitness challenges, such as stair climbing, steps walked, destination themed walks
- VA2K

An organization can help employees incorporate walking through a variety of support structures including attractive and safe pedestrian and bicycle paths, leadership backing for walking groups, stairwell projects that create an appealing alternative to elevator or escalator use, inspirational posters, and assistance with communication and organization. Walking requires no special clothing, equipment, or training.

#### *9.5.4.2 Security, Safety, and Hygiene Issues*

In developing a physical activity program, it is important to identify and address security, safety, and hygiene issues, and to incorporate these measures into the overall design plan. Whether creating walking paths or setting up fitness areas, the organization should include representation from Safety, Infection Control, Facility Engineering, Environmental Management, and Security to ensure that regulations are followed and appropriate procedures are in place. For any renovations and/or construction projects, early involvement of facility Engineering Service is crucial. This proactive approach will alleviate potential barriers and provide a sustainable and effective physical activity program.

When developing plans for your fitness activities, carefully consider health industry recommendations on staffing, facility design, equipment selection and maintenance, and safety. The American College for Sports Medicine is a good source for written standards and guidelines. Although the benefits of providing health and fitness activities outweigh the risks, there are liability issues that need to be recognized. It is common for fitness centers to use waivers and informed consent forms for participation in agency-sponsored fitness facilities or events. While this provides information to the participant about risks and limits liability exposure, these forms do not absolve an agency from liability for negligence. A personal fitness certification form can alert an employee to possible risks based on their health status; however, employees cannot waive their right to file worker's compensation claims. Facilities are advised to check with their regional counsel to determine the need for a waiver or other screening forms, and to ensure that it conforms to the appropriate federal, state and local laws.

Many injuries can be prevented through adequate supervision, staff training, appropriate screening procedures, and proper facility and equipment upkeep. A comprehensive safety and emergency plan developed, documented, and posted visibly in the fitness facility is required. To address accidents or other safety issues, there must be an appropriate and timely response, evaluation, and follow-up. Access to automatic external defibrillators (AEDs) within or near the fitness facility is recommended.



#### 9.5.5 Health Events (e.g., health fairs, VA2K)

Health events, such as fairs, walks, challenges or campaigns can be used to raise awareness and motivate employees as well as promote the program. A health event can be used to launch the program or to introduce a new feature of the program. The event can also be a way of collecting baseline data for the program, informing employees about the program, conducting a needs assessment, and providing preventive health education. Key requirements for any event include:

- A planning committee
- An evaluation plan
- Location
- Marketing plan
- Appearance (theme, signage, music, balloons/banners)
- Determination on use of food, music, decorations, activities, health screenings
- Emergency/safety plan
- Volunteers to set up, coordinate activities, register participants and clean up
- Leadership involvement
- Review by regional counsel for liability concerns

Employees may use administrative leave/excused absence for intermittent health and well-being events, such as health fairs, the VA2K, or EWH retreats (as approved by the Medical Center Director).

#### 9.5.6 Complementary and Integrative Health (CIH) Approaches for Employees

Complementary and Integrative Health (CIH) approaches (e.g., yoga, Tai Chi, meditation) can be very useful in building skills for well-being and resiliency. Per VHA policy, employee well-being approaches cannot include services for treatment of illness or injury. This would instead be managed by occupational health or a healthcare provider. [Guidance documents regarding CIH options for employees](https://dvagov.sharepoint.com/sites/VHAOPCC/EWH/Power-of-the-Mind/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2FVHAOPCC%2FEWH%2FPower%2Dof%2Dthe%2DMind%2FShared%20Documents%2FEWH%5FCIH%5FGuidance%2Epdf&parent=%2Fsites%2FVHAOPCC%2FEWH%2FPower%2Dof%2Dthe%2DMind%2FShared%20Documents&p=true&originalPath=aHR0cHM6Ly9kdmFnb3Yuc2hhcmVwb2ludC5jb20vOmI6L3MvVkhBT1BDQy9FV0gvUG93ZXItb2YtdGhLU1pbmQvRVVQUiV1ZEpkGRBZ19rcE5vaXdCNkFCN3piN3EzR3dRZ0xGZEQwQmNJNHY4dz9ydGltZT1hUEc3bWxzYzJFZWw) (<https://dvagov.sharepoint.com/sites/VHAOPCC/EWH/Power-of-the-Mind/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2FVHAOPCC%2FEWH%2FPower%2Dof%2Dthe%2DMind%2FShared%20Documents%2FEWH%5FCIH%5FGuidance%2Epdf&parent=%2Fsites%2FVHAOPCC%2FEWH%2FPower%2Dof%2Dthe%2DMind%2FShared%20Documents&p=true&originalPath=aHR0cHM6Ly9kdmFnb3Yuc2hhcmVwb2ludC5jb20vOmI6L3MvVkhBT1BDQy9FV0gvUG93ZXItb2YtdGhLU1pbmQvRVVQUiV1ZEpkGRBZ19rcE5vaXdCNkFCN3piN3EzR3dRZ0xGZEQwQmNJNHY4dz9ydGltZT1hUEc3bWxzYzJFZWw>) have been published on the EWH SharePoint.

In addition, more information can be found on establishing well-being programming in section 7. Well-being Domain of this *Guide*.

### 9.6 Employee Whole Health: Personal Health Planning

After employees have been introduced to and have experienced Whole Health for themselves through participation in WH102 and/or other core components of Employee Whole Health, they should be encouraged to create a Personal Health Plan (PHP). As previously discussed, the WHS is based on three central components: the Pathway, Well-being Programs, and Whole Health Clinical Care. The PHP—a living document that grounds the approach to care in what matters most to the employee—forms the basis of decision making and treatment planning as the employee moves through the different parts of the system or throughout their wellness and care in the community. This PHP is owned by the employee

and begins with the MAP. Exploration of MAP necessitates self-reflection and can be initiated in any area of the WHS and/or by any member of the employee's healthcare team, including health coaches and/or peers. The PHP links action to the employee's MAP. The action(s) can be self-care approaches or well-being activities as well as shared goals collaboratively created with a clinician/care provider. The resources and support may come from within or outside VA, but the MAP and self-care remain the driving force for the actions.

## 9.7 Employee Whole Health: Clinical Care

As VHA seeks to transform the healthcare delivery model to a Whole Health System, one of the biggest cultural shifts is in clinical care evolution. We are moving from a disease-based, reactionary model, to a personalized, pro-active, team-based, and person-centered approach. When clinicians utilize this approach, they re-engage Veterans in a humanistic interaction. This often eliminates the depersonalization that is so often noted in burnout. We know burnout rates are quite high among health care workers, and we also know that well-being programs alone are not necessarily the full answer. As mentioned at the beginning of this chapter, early outcomes from the initial 18 Flagship Sites for Whole Health implementation show a correlation between employees engaged in Whole Health and improved burnout scores. Clinicians who adopt a Whole Health approach to care for themselves are more likely to use this approach with their Veterans. Their experiences become an important part of their practice patterns, and they are more likely to recommend therapeutic approaches in service of their Veterans' MAP. Hence, clinician Whole Health Clinical Care and EWH are interrelated. By investing in the health and well-being of our front-line providers and instructors, we are investing in the improved care of our Veterans.

The clinician/care provider's role in employee health/occupational health is episodic; however, there are ways to integrate Whole Health principles and approaches into these appointments as well. In employee health/occupational health, it is important for the clinician/care provider to partner with the employee to align their care in support of the employee's MAP and PHP. Employee health/occupational health clinicians/care providers should ask employees "What matters to you and how can we help you live your best life?" These questions can help to understand how to help the recovery process from an illness or injury.

It is also important to note here that unlike Veteran Whole Health, there are employees who will receive the bulk of their clinical care in the community, and that the VA cannot and should not replace the employee's private primary care provider. However, employees can learn about options to support their well-being and pursue resources in their community or network as well. Whole Health literacy is very important for all VA employees.

## 9.8 Employee Whole Health: Community Resources

There are several ways that employees can access health and well-being services. For example, most employees in VA participate in the Federal Employees Health Benefits (FEHB) Program, which provides health insurance coverage for employees and their dependents. Federal employees, retirees, and their survivors enjoy the widest selection of health plans in the country, many of which cover the costs of preventive services (immunizations, screenings for cancer, diabetes, and high blood pressure, and tobacco use cessation services and medications) and may provide access to additional health and well-being services, including health risk assessments, primary care, and chronic disease management.

There are a number of reputable organizations that provide integrative medicine information and well-being resources, including the following:

- [Andrew Weil Center for Integrative Medicine \(AWCIM\)](https://integrativemedicine.arizona.edu/) (<https://integrativemedicine.arizona.edu/>)
- [Academic Consortium for Integrative Medicine and Health \(ACIMH\)](https://imconsortium.org/) (<https://imconsortium.org/>)
- [National Academy of Medicine \(NAM\)](https://nam.edu/about-the-nam/) (<https://nam.edu/about-the-nam/>)

Employees may also access health and well-being services through several personal or independent social, community, family, or church programs. What is offered varies by community, but there may be entities that offer discounts for federal employees and/or Veterans, and employees are encouraged to inquire about such community resources. Information can be obtained by the facility Human Resources Benefits Specialist.

## 9.9 Establishing Evidence of the Value of Whole Health through its Influence on Employee Satisfaction and Engagement

Evaluation is a systematic process to understand what a program does and how well the program does it. Evaluation results can be used to maintain or improve program quality and to ensure that future planning can be more evidence-based. Evaluation constitutes part of an ongoing cycle of program planning, implementation, and improvement. Early attention to process improvement is a characteristic of high reliability organizations and important to the VHA culture.

Evaluation falls into one of two broad categories: qualitative and quantitative. Qualitative evaluations are conducted during program development and implementation and are useful in defining goals or improving programs, and very impactful in sustaining implementation efforts prior to good quantitative data. Quantitative evaluations should be completed in order to describe: (1) the baseline status of a population; (2) the extent to which a program is achieving its goals; and/or (3) program outcomes.

In general, it is good to have a mix of qualitative and quantitative measures to evaluate program success. From a national program office perspective, OPCC&CT will be focusing on the following largely qualitative strategies in the upcoming year to better understand program development and implementation:

- Assessment of employee involvement with Whole Health activities and personal use of Whole Health (All Employee Survey)
- A data call survey for administration to each medical center's leadership to assess current status on activities related to implementation, training, and program specific activities (Healthcare Analysis and Information Group survey)
- Phone-based interviews to understand implementation facilitators and barriers for Employee Whole Health and well-being
- Phone-based interviews to understand the personal experiences of employees who have participated in Employee Whole Health programs offered by their facility

### 9.9.1 Qualitative Evaluation

An important component of qualitative data collection is known as process evaluation. Process evaluation typically examines both the overall program and the actual programs (i.e., what was and was not done). Evaluation of the program will help assess how well programs were carried out, what types of problems were encountered, who participated, and if the expected outcomes were achieved. It may also include an assessment of who responded to surveys, and who decided to participate in programs.

Process evaluation may be broken into several basic areas:

- Description of the program environment
- Documentation of methods used to design and implement the program operations, including any changes in the program
- Identification and description of events that may have affected program implementation and maintenance

A sample process evaluation is summarized in the tables below. Program staff may wish to create and complete a checklist of items pertaining to the implementation of different elements of their program. Process measures are best if they are completed on an ongoing basis.

There are other types of qualitative information that you may be interested in collecting as part of your program design and implementation efforts including employee testimonials. This information is important to collect as part of early efforts to show potential program benefits.

#### 9.9.1.1 Describing the Program Environment

**Describing the program environment includes asking the following questions about the site's Employee Whole Health Committee/Workgroup, gap analysis, and EWH coordinator.** A gap analysis is a technique used for determining the steps to be taken in moving from a current state to a desired future state. Gaps in programming and personnel are identified so that plans can be made to address those needs.

*Table 11: Assessment Questions for Describing the EWH Program Environment*

Category	Process Evaluation Question(s)	Data Collection Method
<b>Employee Whole Health Committee/Workgroup</b>	Was the committee/workgroup formed on a timely basis?  Does the committee/workgroup have the right stakeholders and representation?  Did committee/workgroup members participate on an ongoing basis?	Records of attendance, minutes and/or participation from the committee/workgroup

Category	Process Evaluation Question(s)	Data Collection Method
<b>Gap Analysis</b>	Was a gap analysis conducted?  Was the gap analysis completed in a timely fashion?	Results of gap analysis
<b>Employee Whole Health Coordinator</b>	Was the Employee Whole Health coordinator able to work with the committee/workgroup in order to meet existing needs?	Committee/workgroup notes and minutes

### 9.9.1.2 Design and Implement Program Operations

**Assessing program design and implementation requires consideration of both resources and barriers.**

*Table 12: Assessment Questions for EWH Program Operations*

Category	Process Evaluation Question(s)	Data Collection Method
<b>Resources</b>	Were the necessary resources available to educate, market/communicate, offer, and document the following:  To carry out program objective(s)?  To enroll and support employees/participants?  To train Employee Whole Health staff?	Employee Whole Health coordinator records  EWH Committee/workgroup charter and notes
<b>Barriers</b>	What were the participation barriers for the following groups:  For committee/workgroup members?  For EWH staff?  For employees/participants?	EWH coordinator records  Interviews

### 9.9.1.3 Description of Factors that May have Affected Employee Whole Health Program Implementation

**Many factors can influence EWH program implementation.** It is expected that the EWH coordinator and staff will keep records of these facilitating or obstructing factors and how they impacted staff Whole Health education, the communication and marketing of Whole Health offerings, health coaching for employees, and implementation of well-being offerings for staff.

*Table 13: Assessment of Factors Impacting EWH Program Implementation*

Category	Process Evaluation Question(s)	Data Collection Method
<b>Factor Identification</b>	What factors influenced implementation of the program?	EWH coordinator and staff records
<b>Education of staff on Whole Health concepts</b>	Did EWH staff attend the training session?  What were EWH staff perceptions of the training sessions?  What were the barriers to attending training sessions?	EWH coordinator records  Personal interviews with EWH staff conducted by the program office  Program evaluation forms from Employee Education System (EES)
<b>Communications/marketing of new EWH offerings</b>	What methods were used to advertise offerings?  Which method was most effective?	Copies of promotional e-mails, posters, etc.  Brief questionnaire of employees asking how they heard about the offering(s)
<b>Implementation of health coaching for employees</b>	Level of employee interest?  Level of employee participation?  Barriers to employee participation?	Results of needs assessment  Participation records/log  Questionnaire/interview of employees regarding barriers (i.e., time to participate, scheduling, etc.)
<b>Implementation of well-being programs for employees</b>	Level of employee interest?  Level of employee participation?  Barriers to employee participation?	Results of needs assessment  Participation records/log  Questionnaire/interview of employees regarding barriers (i.e., time to participate, scheduling, etc.)

### 9.9.2 Quantitative Evaluation

Once you have an Employee Whole Health program(s) up and running, there are many quantitative methods that can be used to evaluate program effectiveness. At the most basic level, what you are trying to determine is whether or not employees participating in your program(s) are making or experiencing any measurable changes in their behavior, stress levels, or health status as it relates to the program(s) they are participating in. In order to assess this, you will need to know something about whatever measure or outcome you are interested in before employees start the program, as well as after they finish it. This is why you need to think about how you will evaluate the program prior to starting it – because you will need to get assessments from employees before they start taking part in your Employee Whole Health program offering(s). It is also a best practice to ask employees about their satisfaction with program offerings. We have created an Evaluation Toolkit to aid you in your program evaluation efforts. The toolkit includes a series of measures and scales for use in evaluation efforts covering a broad range of topics including employee resiliency and stress, general health status and quality of life, organizational climate and culture, as well as select measures to assess interventions and/or offerings for each area of the Circle of Health. A sample satisfaction survey to gather feedback on local EWH efforts is also included.

The general Whole Health Evaluation Toolkit and an Employee Whole Health Evaluation Toolkit are found on the [Research and Evaluation SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/SitePages/Research-Evaluation.aspx?OR=Teams-HL&CT=1625238380817) (<https://dvagov.sharepoint.com/sites/VHAOPCC/SitePages/Research-Evaluation.aspx?OR=Teams-HL&CT=1625238380817>).

A simple example to consider is looking at the change in the stress levels of employees who participate in an 8-week stress management class. Keep in mind that, when working with employee populations, it is important to keep any questionnaires or surveys brief due to the limited amount of time employees generally have to participate. In this example of a stress management program, you might consider using the [Perceived Stress Scale \(PSS\)](https://dvagov.sharepoint.com/:b:/s/VHAOPCC/WH-Implementation/EX8xsJf_b7hBIE8xpT_wN_YBpad13UgogtUbngNxrQA?e=FMmzUm) ([https://dvagov.sharepoint.com/:b:/s/VHAOPCC/WH-Implementation/EX8xsJf\\_b7hBIE8xpT\\_wN\\_YBpad13UgogtUbngNxrQA?e=FMmzUm](https://dvagov.sharepoint.com/:b:/s/VHAOPCC/WH-Implementation/EX8xsJf_b7hBIE8xpT_wN_YBpad13UgogtUbngNxrQA?e=FMmzUm)), which is a brief 10-item scale used to measure the degree to which situations in one's life are appraised as stressful. Alternatively, for a healthy eating/lifestyle nutrition program, you might consider measuring changes in weight or eating behaviors over time using the [Mindful Eating Questionnaire \(MEQ\)](https://dvagov.sharepoint.com/:b:/s/VHAOPCC/WH-Implementation/EWXkjqEcuxAiMce3EjhbA0BoMiAVV7kvZ7eR0ncQwXUlw?e=Src1M) (<https://dvagov.sharepoint.com/:b:/s/VHAOPCC/WH-Implementation/EWXkjqEcuxAiMce3EjhbA0BoMiAVV7kvZ7eR0ncQwXUlw?e=Src1M>).

Be aware that use of the MEQ requires permission, while the use of the PSS does not. This is another important thing to keep in mind for quantitative evaluation – that is, depending on the outcome(s) you are interested in, you may need to seek approval prior to using the measurement tool of your choice. Also note that, for the purposes of program evaluation, you will be looking at aggregate changes in the population over time. For example, does the average stress score on the PSS across participants decrease after employees participate in the stress management class compared to the average at baseline?



The Employee Whole Health coordinator or committee may be interested in learning about the overall impact of a program or offering on the population as a whole through the examination of a number of factors. One measure to consider for this is the PIPE Impact Metric described in the following section.

#### *9.9.2.1 PIPE Impact Metric*

A more quantitative approach that may allow you to understand the population impact of Employee Whole Health programs is the PIPE Impact Metric. This metric is designed to monitor program impact in relationship to its stated objectives and processes. The metric has four elements: penetration, implementation, participation, and effectiveness. The metric is calculated by multiplying the four elements together to derive the population health impact. The definition of each element is as follows:

P - Penetration: The proportion of the target population that is reached with invitations to the program

I - Implementation: The degree to which the program has been implemented

P - Participation: The proportion of employees who enroll or participate in any aspect of the program

E - Effectiveness: The rate of success among participants

PIPE Impact Metric = Penetration x Implementation x Participation x Effectiveness

Penetration and implementation are related to the energy and effort required for program design and administration. Participation and effectiveness reflect employee engagement. The first two elements (penetration and implementation) inform program administrators about opportunities for improvement. The second two elements (participation and effectiveness) are used for reporting on program outcomes. The PIPE Impact Metric may also be used to document changes in population health impact between measurement periods.

The [PIPE Impact Metric is described in detail in a 2003 article by Nicolaas Pronk](https://dvagov.sharepoint.com/:b:/s/VHAOPCC/WH-Implementation/Edefglpc7K1Aoq-Nr9CjCYkBmcct5fLY1-yhg4pBVDvKg?e=Rrb6Q5)

(<https://dvagov.sharepoint.com/:b:/s/VHAOPCC/WH-Implementation/Edefglpc7K1Aoq-Nr9CjCYkBmcct5fLY1-yhg4pBVDvKg?e=Rrb6Q5>).

In addition, you may refer to an example of [how to calculate the PIPE Impact Metric](https://dvagov.sharepoint.com/:w:/s/VHAOPCC/WH-Implementation/ERII1e6N0xNHrELLnhJJ0loBLfRpmZi3SL5iPWRISYtlyQ?e=hiEFTC)

(<https://dvagov.sharepoint.com/:w:/s/VHAOPCC/WH-Implementation/ERII1e6N0xNHrELLnhJJ0loBLfRpmZi3SL5iPWRISYtlyQ?e=hiEFTC>).

#### *9.9.3 Approaches to Data Documentation and Tracking*

In the future, the programs and services offered through Employee Whole Health will be documented in a manner similar to how patient encounters are currently documented for Veterans' Whole Health services. However, for now the approved system of records for employee medical information in VA is the Employee Medical Folder (EMF). The categories of records currently documented in this system include the following:

1. Medical records, forms, and reports completed or obtained when an individual applies for a Federal job and is subsequently employed
2. Medical records, forms, and reports completed during employment as a condition of employment, either by the VA or by another agency, State or local government entity, or a private sector entity under contract to the VA

3. Records resulting from the testing of the employee for use of illegal drugs under Executive Order 12564
4. Files containing reports of on-the-job injuries and medical records, forms, and reports generated as a result of the filing of a claim for Workers' Compensation, whether the claim is accepted or not
5. All other medical records, forms, and reports created on an employee during his or her period of employment, including records retained on a short term/temporary basis (i.e., those designated to be retained only while the employee is with the VA) and records designated for long-term retention (i.e., those retained for the employee's duration of Federal service and for some period of time thereafter)

To document well-being services provided as part of an Employee Whole Health program, a new system of records notice (SORN) will be written and published in the Federal Register. This SORN will outline an additional category of records to document and track on employees, namely records resulting from participation in agency-sponsored health and well-being activities, including health assessments (i.e., Personal Health Inventory, Personal Health Plan, health coaching, disease management, behavioral management, preventive services, fitness programs, and any other activities that could be considered part of a comprehensive worksite health and well-being program.

#### 9.9.4 Implementation Case and Impact on Organizational Metrics

Over time, robust Employee Whole Health programs should have an impact on important organizational metrics. Indeed, early national results from the evaluation of the impact of Whole Health on Veteran care also revealed important, positive findings on staff-related measures such as motivation, turnover, and burnout for employees involved with Whole Health. These results came from VA's annual organizational census survey, the All Employee Survey (AES). Specifically, in a survey of clinical staff at the Flagship and Whole Health Design sites (n=42,213) regarding their involvement in Whole Health, higher involvement scores were significantly related to overall job satisfaction, burnout, workload satisfaction and drivers of engagement. Facilities with higher employee involvement in Whole Health also had higher ratings on hospital performance, as measured by the Strategic Analytics for Improvement and Learning (SAIL). For access to the full report discussing these findings, refer to the [February 2020 Whole Health System Evaluation of Care Progress Report](https://www.va.gov/WHOLEHEALTH/docs/EPCCWholeHealthSystemofCareEvaluation-2020-02-18FINAL_508.pdf) ([https://www.va.gov/WHOLEHEALTH/docs/EPCCWholeHealthSystemofCareEvaluation-2020-02-18FINAL\\_508.pdf](https://www.va.gov/WHOLEHEALTH/docs/EPCCWholeHealthSystemofCareEvaluation-2020-02-18FINAL_508.pdf)). The final Flagship evaluation report, along with other related reports, will be housed on the [OPCC&CT Research & Evaluation SharePoint](https://www.va.gov/WHOLEHEALTH/professional-resources/clinician-tools/Evidence-Based-Research.asp) (<https://www.va.gov/WHOLEHEALTH/professional-resources/clinician-tools/Evidence-Based-Research.asp>).

As medical centers continue to implement Whole Health offerings and services for their staff, improvements in these key metrics are expected to occur. Thus, monitoring changes in AES scores and SAIL metrics at the local level is an important way to show the value of EWH programs. However, keep in mind that there are a number of other things within a medical center that may impact these measures, so there are some limitations to using these data. However, it is still important to evaluate offerings and services individually as described above, and this should be done in addition to looking at these other higher-level metrics.

Peer-reviewed literature is also a source of information that EWH staff can use to support local efforts around EWH and to build the business case for well-being at their medical centers. In terms of looking at

the business case for employee well-being, in the past few years there has been a move away from viewing Return on Investment (ROI) estimates derived from health care cost savings as the preferred method to assess the impact of health and well-being programs. Alternatively, programs are increasingly being evaluated for their **Value on Investment (VOI)**, as described in a [2016 article by Ozminkowski et al](https://dvagov.sharepoint.com/:b:/s/VHAOPCC/WH-Implementation/Efzl6Bgib5NJhct5ho5knLsBbANWbsDWEXu378pOh2WQpg?e=vUPI4Z) (https://dvagov.sharepoint.com/:b:/s/VHAOPCC/WH-Implementation/Efzl6Bgib5NJhct5ho5knLsBbANWbsDWEXu378pOh2WQpg?e=vUPI4Z). VOI incorporates a number of other metrics to determine program impact, including employee morale, reduced turnover, health risk reduction, reduced sick or disability days, higher productivity at work, and improved quality of life. The VOI approach also aligns with the intent of EWH and scope of evaluation efforts in VHA.

Finally, a number of [articles on employee well-being in the VHA](https://dvagov.sharepoint.com/:f:/s/VHAOPCC/WH-Implementation/EIMKeZ0YOMZJnVclvZrY_eEBGd2s6-XTpRHVcZ4f6cNFgQ?e=7bFa3e) (https://dvagov.sharepoint.com/:f:/s/VHAOPCC/WH-Implementation/EIMKeZ0YOMZJnVclvZrY\_eEBGd2s6-XTpRHVcZ4f6cNFgQ?e=7bFa3e) specifically have been published over the last several years and would be good background information for EWH staff.

## Resources

[Employee Whole Health Domain SharePoint Document Library](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Employee_WH_Domain/Forms/AllItems.aspx)

(https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Employee\_WH\_Domain/Forms/AllItems.aspx).

[Employee Whole Health section of the Whole Health Hub](https://dvagov.sharepoint.com/sites/VHAOPCC/ewh)

(https://dvagov.sharepoint.com/sites/VHAOPCC/ewh)

[Employee Whole Health FAQs](https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/WH-Implementation/Employee_WH_Domain/FAQ_EWH.docx?d=w11eb6c74a63e423b9ee8687056d2d077&csf=1&web=1&e=4moFUU) (https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/WH-

Implementation/Employee\_WH\_Domain/FAQ\_EWH.docx?d=w11eb6c74a63e423b9ee8687056d2d077&csf=1&web=1&e=4moFUU)

## 10. Community Partnerships Domain

### 10.1 What is Community Outreach?

Community outreach refers to efforts that connect your organization's ideas or practices to resources in the community to improve the depth and breadth of the Veteran experience. Unlike marketing, which is focused on products or strategies that increase market share, outreach takes on an educational component that engages the community in Veteran care. Outreach strategies are most beneficial when linked to the organization's mission. Site and community partners should work collaboratively in the marketing and outreach strategy.

**Community outreach raises awareness of Whole Health in the community and improves the ability to reach target populations, including alignment with strategic priorities and key programs.** More specifically, forming partnerships with external organizations is a great way to reach more Veterans in the community, identify new spaces for delivering Whole Health services, and enlist support from the broader community. Potential community partnerships include local YMCA's, Veteran Service Organizations (VSOs), education facilities and community centers. However, this list is not exhaustive, and sites are encouraged to explore options available within the local community.

There are also offices within VA that can help organize and develop your external partnerships. The following sections describe useful links and documents to support initiating and forming external collaborations.

### 10.2 Internal VA Resources

Veteran Community Partnerships (VCP) is a national initiative to ensure that all Veterans and their caregivers have access to the widest range of choices and services. VCP is a joint project of Veterans Health Administration's (VHA) Offices of Geriatrics and Extended Care, Community Engagement, Rural Health, and Caregiver Support. VCPs are coalitions of Veterans and their caregivers, Department of Veterans Affairs (VA) facilities, community health providers, organizations, and agencies working together to foster seamless access to, and transitions among, the full continuum of care and support services in VA and the community.

Nationally, the [Veterans Experience Office \(VEO\)](https://dvagov.sharepoint.com/sites/VACOVEO) (<https://dvagov.sharepoint.com/sites/VACOVEO>) has created [Community Veterans Engagement Boards \(CVEBs\)](https://dvagov.sharepoint.com/sites/VACOVEO/CXEngagement/SitePages/Community-Veteran-Engagement-Boards-(.aspx)) ([https://dvagov.sharepoint.com/sites/VACOVEO/CXEngagement/SitePages/Community-Veteran-Engagement-Boards-\(.aspx\)](https://dvagov.sharepoint.com/sites/VACOVEO/CXEngagement/SitePages/Community-Veteran-Engagement-Boards-(.aspx))) across the country, with multiple boards within each state. Additionally, the VEO has created tools and resources for community engagement that can be located using the links above.

The VHA Office of Community Engagement serves as a trusted resource and catalyst for the growth of effective partnerships at all levels that benefit Veterans. Beyond VHA, the Office of Community Engagement serves as a facilitator and an entry point for public and private entities interested in partnering with VHA in the service of Veterans. The VA has also established the VA Secretary's Center for Strategic Partnerships, as well as published a directive containing guidance regarding public-private partnerships. Links to these and other important resources include:

- [Office of Community Engagement website](http://vaww.oce.med.va.gov/Default.aspx) (<http://vaww.oce.med.va.gov/Default.aspx>)

- [Office of Community Engagement Partnership Due Diligence Vetting Form](http://vawww.oce.med.va.gov/PartDueDill.aspx) (http://vawww.oce.med.va.gov/PartDueDill.aspx): This step-by-step Due Diligence Vetting Form will standardize the process by which VA staff can vet potential partners and validate proposed partnerships.
- [Veteran Community Partnerships website](https://www.va.gov/healthpartnerships/vcp.asp) (https://www.va.gov/healthpartnerships/vcp.asp)
  - Use the [VCP Coordinator Roster](https://www.va.gov/HEALTHPARTNERSHIPS/docs/VCPCoordinatorsRoster.doc) (https://www.va.gov/HEALTHPARTNERSHIPS/docs/VCPCoordinatorsRoster.doc) to identify primary contacts at local facilities.
  - The [VCP Toolkit](https://www.va.gov/HEALTHPARTNERSHIPS/docs/VCPToolkit.pdf) (https://www.va.gov/HEALTHPARTNERSHIPS/docs/VCPToolkit.pdf) provides “direction, strategy, resources and tools to build and strengthen partnerships among Veterans and their caregivers, VA, and community partners.”
- [VA Secretary’s Center for Strategic Partnerships](https://www.va.gov/scsp/index.asp) (SCSP) website (https://www.va.gov/scsp/index.asp): SCSP’s stated mission is “Improving Veterans lives through big, bold, and impactful collaborations.” It’s current focus is to create “partnerships aimed at increasing access to and improving the quality of healthcare, extending broadband internet access to rural and low-income Veterans, delivering expansive telehealth services to better serve our patients, driving best in class oncology care, and providing attractive employment opportunities.”
- [VA Directive 0008- Developing Public-Private Partnerships with, and Accepting Gifts to VA from, Non-Governmental Organizations](http://vawww.va.gov/vapubs/viewPublication.asp?Pub_ID=803&FTYPE=2) (http://vawww.va.gov/vapubs/viewPublication.asp?Pub\_ID=803&FTYPE=2) establishes policy on how to develop and maintain responsible and productive public-private partnerships with non-governmental organizations.
- [Public-Private Partnership \(P3\) Resources](http://vawww.oce.med.va.gov/P3Guidance.aspx) (http://vawww.oce.med.va.gov/P3Guidance.aspx)
- [OPCC&CT’s Whole Health Outreach Toolkit](https://www.va.gov/WHOLEHEALTH/get-involved/outreach-toolkit.asp) (https://www.va.gov/WHOLEHEALTH/get-involved/outreach-toolkit.asp)

### 10.2.1 Vet Centers

**Vet Centers are community-based counseling centers that provide a wide range of social and psychological services, including professional readjustment counseling to eligible Veterans, active duty service members, including National Guard and Reserve components, and their families.** While the Vet Centers are not part of the VA Medical Centers, they are part of the Veteran Health Administration and a great resource for Veterans in your communities with more than 300 Vet Centers nationwide, Mobile Vet Centers, and a dedicated Vet Call Center. Readjustment counseling is especially equipped with resources to help Veterans make a successful transition from military to civilian life or after a traumatic event experienced in the military. Individual, group, marriage and family counseling is offered in addition to referral and connection to other VA or community benefits and services. Vet Center counselors and outreach staff, many of whom are Veterans themselves, are experienced and prepared to discuss the tragedies of war, loss, grief and transition after trauma. In 2019 the Vet Centers embarked on a national endeavor to train their staff in principles of Whole Health and have continued to journey implementing Whole Health in their practice. Many locations are looking to partner with VAMCs to continue implementing Whole Health in delivering care. To learn more about Vet Centers and to connect with your local office please visit their website [Vet Centers \(Readjustment Counseling\)](https://www.vetcenter.va.gov/) (https://www.vetcenter.va.gov/).

## 10.3 Assessing the Local Environment

Collaboration is essential between federal, state and local agencies, academic institutions, private health care providers, non-profits and others in our communities to effectively meet the needs of Veterans, their families, caregivers and survivors. Through partnerships we can add depth and breadth to our community impact and better support our nation's Veterans and their families. Seeking community partnerships is an excellent option to expand available space.

**Since partnership opportunities can vary from facility to facility it is important to assess the local environment to find the unique opportunities available to your facility.** Thoughtful selection of potential partners will help assure that Veterans can be exposed to the Whole Health message in multiple areas of their life, not just in healthcare settings. For example, consider partnerships in the realms of education (colleges/universities), social support (VFW, Military Moms, senior centers), recreation (YMCA/YWCA), religion (faith-based organizations), etc. **Potential partners include:**

- AARP
- Adult Day Care programs
- Alzheimer's Association
- American Cancer Society
- American Legion
- American Red Cross
- Area Agencies on Aging
- Assisted Living Facilities
- Brain Injury Association
- Cancer Charities
- Caregiver Services
- Community Mental Health Centers
- Department of Health and Human Services
- Division of Aging (state/regional)
- Easter Seals
- Faith-based organizations
- Funeral Homes
- Home health care agencies
- Hospice providers
- Hospitals
- Individual Veterans
- LGBTQ+ organizations
- Legal Aid Services
- Local and state government representatives
- Local Counseling Centers (county and private)
- Long term care facilities
- Military Moms
- Nursing & Rehabilitation Centers
- Senior Centers

- Senior Services/Centers
- State Veteran's Homes
- Universities/colleges
- Veteran Service Organizations (e.g. Disabled American Veterans, American Legion, VFW, Wounded Warriors, Team RWB etc.)
- Veterans Council
- Women's Health Clinics
- YMCA/YWCA
- And others, depending on their mission and strategic focus

While identifying new community partners is important, one of the easiest ways to begin is by starting with current partnerships to look for opportunities to improve the depth of those alliances. Thus, your environmental scan should include reaching out to the following types of internal services/staff as the most likely to have an awareness of existing community partners:

- Public Affairs/Public Affairs Officer
- Center for Development and Civic Engagement Service (formerly Voluntary Service)
- Social Work Service
- Post 9/11 Military2VA Care Management (formerly Transition Care Management)
- Mental Health
- Health Promotion Disease Prevention Coordinator
- Nutrition & Food Services
- Veteran/Patient Experience Office
- And others

## 10.4 Local Partnerships for Provision of Whole Health Approaches

Local partnerships can extend the reach of the Whole Health approach, focusing on the site's prioritized areas of need and/or value that could be met via community partnerships. These areas of need/value are informed by environmental scans and established through the process of developing the facility's Whole Health strategic plan. Robust partnerships are considered most beneficial when Veterans receive education regarding personal health planning during community partnership encounters, when feasible and applicable, and can engage in personal health planning which then has an avenue for that information to be connected back to the VA.

Whole Health-related community partnerships vary in scope and complexity. Some examples of these partnerships include:

- National VA partnership with YMCA to offer Whole Health programming, services, space and resource sharing at local YMCAs. The Indianapolis VA has located a clinic within a local YMCA
- Local Asheville VA partnership with the COPD Foundation for their "Harmonicas for Health" program
- Offering *Introduction to Whole Health* classes in the community. Example of [Introduction to Whole Health Community Partner Checklist](https://dvagov.sharepoint.com/:w:/s/VHAOPCC/WH-Implementation/ET3KEz394pJFhcrD2jZjMtoBVP7ZDwGq_V5SVjC9KMWwRw?e=fYaCZt) (https://dvagov.sharepoint.com/:w:/s/VHAOPCC/WH-Implementation/ET3KEz394pJFhcrD2jZjMtoBVP7ZDwGq\_V5SVjC9KMWwRw?e=fYaCZt)



- Local Kansas City VA partnership with Cultivate KC to provide monthly \$5.00 vouchers for locally grown fresh foods to Veterans that qualify
- Local Kansas City VA partnership with art museum to provide art classes with a mindfulness component
- Local Harry S. Truman Memorial VA (Columbia, MO) partnership to provide healing touch services
- Local Toledo CBOC (VA Ann Arbor) partnership with the Toledo Bar Association to provide free monthly walk-in clinics for Veterans with legal concerns

Through the planning process, sites should be able to identify the projected increase in capacity of Whole Health approaches and reach through the use of community partnerships. A plan should be developed for outreach to and engagement of community partners. However, the most effective partnerships will be those that go beyond just outreach activities that encourage utilization of VA's services. True partners will:

- Share aligned goals and work collaboratively to achieve them
- Be equally committed to the positive outcomes of their endeavors
- Seek to improve the quality of care and services by selflessly combining resources
- Understand and value the importance of each other's contributions

**A careful review and full understanding of a potential partner's mission and strategic focus is recommended before entering into a formal partnership agreement.** When developing Memorandums of Understanding (MOUs) between the VA site and the community organization, national MOUs should be leveraged at the local level whenever possible and beneficial. Oftentimes a national MOU can be used at the facility level without addendums, but sites should seek guidance from leadership and local counsel. MOUs should be written to clearly outline the expectations and boundaries of the services to be provided.

- Refer to the full list of [VA National Memorandums of Understanding \(MOUs\)](http://vaww.oce.med.va.gov/MOUs.aspx) (<http://vaww.oce.med.va.gov/MOUs.aspx>), which includes MOUs for YMCA/YUSA, Wounded Warrior, Project HERO, Center for Women Veterans, and others
- Explore [examples of locally-developed MOUs and MOU templates](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Community_Domain/Forms/AllItems.aspx?viewid=0300beea%2D953e%2D44aa%2Dac3e%2Df2216086801f&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FCommunity%5FDomain%2FMOU%5FExamples) ([https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Community\\_Domain/Forms/AllItems.aspx?viewid=0300beea%2D953e%2D44aa%2Dac3e%2Df2216086801f&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FCommunity%5FDomain%2FMOU%5FExamples](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Community_Domain/Forms/AllItems.aspx?viewid=0300beea%2D953e%2D44aa%2Dac3e%2Df2216086801f&id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FCommunity%5FDomain%2FMOU%5FExamples))

In addition to setting the expectations for both parties, MOUs can incorporate mechanisms to solicit Veteran feedback on the value and satisfaction derived from attending/receiving Whole Health services/activities from a community partner. Such feedback could be used to assess the effectiveness of the partnership, estimate usage rates, suggest improvements/enhancements to the partnership, and/or be used to inform community partner appreciation/recognition events. Recognition of community partners could be incorporated into a facility's existing calendar of events, such as Volunteer Recognition Week ceremonies.

Finally, sites should establish mechanisms to create awareness amongst Veterans and staff about community partners offering Whole Health resources, activities, and services. Such awareness

campaigns/marketing should be incorporated into the facility's Whole Health communication plan in collaboration with Public Affairs, any existing outreach committee, etc. (See section 5.6 Communications and Advertising in this *Guide* for more information about communications planning). One method of creating awareness for staff is to develop an online directory of Whole Health services (both internal and external) using SharePoint, the VA intranet, or another approved digital platform. Resource directories can also be created and provided to Veterans. For example, this [Whole Health Resource Guide from Detroit VA](https://dvagov.sharepoint.com/:w:/s/VHAOPCC/WH-Implementation/Eb2kP-iMnUBGn7vfkI_NsOYBtBV7pvNzD41gEXCAtkf6gQ?e=Uc7Fz9) (https://dvagov.sharepoint.com/:w:/s/VHAOPCC/WH-Implementation/Eb2kP-iMnUBGn7vfkI\_NsOYBtBV7pvNzD41gEXCAtkf6gQ?e=Uc7Fz9) is structured around the eight components of self-care and includes related community resources for each component.

## 10.5 Contributions by Volunteers

Volunteers are a priceless asset to the Nation's Veterans and to the Department of Veterans Affairs. Volunteers are not only valuable, but for many sites they are also a critical resource for Whole Health implementation. Volunteers may be friends or family members of the Veteran or Veterans who are interested in supporting the work (they may even have already participated in Whole Health or patient-centered programs). Potential volunteers can be recruited by:

- Partnering with a local Veteran Service Organization or Civic group
- Meeting with your local Center for Development and Civic Engagement Service representative to determine if they can help with recruitment of facilitators and/or serve as facilitators
- Soliciting recommendations from staff
- Collaborating with the site's local Veterans Council, Patient-Family Centered Care Committee or other similar entity

To locate your local Center for Development and Civic Engagement Service coordinator, search the [VA Volunteer Directory website](https://www.volunteer.va.gov/directory/index.asp) (https://www.volunteer.va.gov/directory/index.asp).

Another resource for volunteer policy guidance and identification of existing external partnerships is the Center for Development and Civic Engagement's [National Advisory Committee](https://www.volunteer.va.gov/NAC.asp) (https://www.volunteer.va.gov/NAC.asp).

Regardless of their background, Volunteers can play an essential role in transitioning and maintaining a site to the Whole Health System. Volunteers are often used as peer facilitators and to provide wellness classes in yoga, tai chi, and other CIH approaches. Examples of both national and facility-level position descriptions for these and other volunteer roles can be found on the Whole Health [Volunteer Positions folder on SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WHHumanResources/Forms/AllItems.aspx?id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FWHHumanResources%2FWH%5FPositions%2FVolunteer%5FPositions&viewid=81726be2%2D9a7a%2D41d3%2D9af2%2D6c06f7dc0d21) (https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/WHHumanResources/Forms/AllItems.aspx?id=%2Fsites%2FVHAOPCC%2FWH%2DImplementation%2FWHHumanResources%2FWH%5FPositions%2FVolunteer%5FPositions&viewid=81726be2%2D9a7a%2D41d3%2D9af2%2D6c06f7dc0d21).

Further information about the training and use of volunteers can be found in sections 5.2.4 Enlisting Volunteers to Support Whole Health and 7.2.3 Staffing Well-being Programs of this *Guide*.

## 10.6 National and Interagency Partnerships

National and interagency partnerships include the Department of Defense (DoD), Veteran Service Organizations (VSOs), etc. These partnerships can be leveraged at the local level to support outreach and engagement of community partners. These partnerships can also be utilized to coordinate, support,

and extend the reach of Whole Health by exploring opportunities to share resources, educate, and/or recruit volunteers. As stated previously, any existing national Memorandums of Understanding (MOUs) should be used wherever possible to streamline the process of engaging with the partners. Useful resources in this area include:

- The list of [VA National Memorandums of Understanding \(MOUs\)](http://vawww.oce.med.va.gov/MOUs.aspx) (<http://vawww.oce.med.va.gov/MOUs.aspx>), which includes MOUs for YMCA/YUSA, Wounded Warrior, Project HERO, Center for Women Veterans, and others
- [Directory of Veteran and Military Service Organizations and State Directors](https://www.va.gov/vso/) (<https://www.va.gov/vso/>) published by the Department of Veterans Affairs

## 10.7 Education and Training for Community Partners

Education and training for community partners is a strategy which can and should be used to ultimately strengthen the Whole Health message for Veterans and to serve as a way for each organization to learn from the other. Just as VA employees who experience Whole Health are believed to be more likely to recommend Whole Health approaches to Veterans, the same reasoning can be used for providing Whole Health training to staff working for our community partners. For Veterans, hearing the Whole Health message across multiple environments provides reinforcement and continuity. Thus, community partner staff should be exposed to Whole Health training/orientation, an explanation of personal health planning and, whenever possible, experiential elements. Offering the *Introduction to Whole Health* class is one way to accomplish this. It is strongly recommended that the provision of such training be included as part of a site's community outreach plan.

## 10.8 Expansion of Community Outreach

Once the initial Whole Health community partnerships have been established, consider additional collaborations that capitalize on multiple partnerships across a variety of settings. This will establish a robust network of community partners collectively embracing the Whole Health approach. By creating these seamless connections, true integration occurs, allowing Veterans to benefit from the array of offerings in both the VA and in the community.

## 10.9 Social Determinants of Health

No discussion about communities and Whole Health would be complete without a full recognition and clear understanding of the role of Social Determinants of Health (SDOH) in health outcomes. According to the [SDOH page of the VA Office of Health Equity \(OHE\) website](https://www.va.gov/HEALTHEQUITY/Social_Determinants_of_Health.asp) ([https://www.va.gov/HEALTHEQUITY/Social\\_Determinants\\_of\\_Health.asp](https://www.va.gov/HEALTHEQUITY/Social_Determinants_of_Health.asp)):

"Genetic factors and health care access are not the only determinants of an individual's health outcomes. Minority populations often face barriers to health in their everyday lives, such as food insecurity, housing instability, transportation challenges and a lack of employment opportunities. These factors are referred to as social determinants of health: the social, economic, and physical conditions in the environments where people live, work, and play. Social and economic disadvantages such as poverty, lack of educational opportunity, food insecurity, or neighborhood crime can result in poor health outcomes and health disparities."

The OHE website offers data, tools, research, and other resources to “help eliminate racial, ethnic, and socioeconomic disparities experienced by Veterans.” One such tool on the OHE website is the *Veterans Geography of Opportunity tool* which sites can use to identify the specific SDOH factors impacting their local Veteran population. Sites are urged to utilize these tools to conceive of and develop appropriate interventions/actions wherever possible. Such interventions can be incorporated into the site’s Whole Health strategic plan.

The National Social Work Program Office released a document produced by the National Social Work Leadership Council Best Practices Committee, [SW-LC Diversity and Inclusion Facilitation Guide](https://dvagov.sharepoint.com/sites/social-work-matters/VA%20SW%20Leadership%20Council%20Documents/Forms/AllItems.aspx?id=%2Fsites%2Fsoci al%2Dwork%2Dmatters%2FVA%20SW%20Leadership%20Council%20Documents%2FSW%2DLC%20Diver sity%20and%20Inclusion%20Facilitation%20Guide%20May%202021%20FINAL%2Epdf&parent=%2Fsites %2Fsoci al%2Dwork%2Dmatters%2FVA%20SW%20Leadership%20Council%20Documents) (https://dvagov.sharepoint.com/sites/social-work-matters/VA%20SW%20Leadership%20Council%20Documents/Forms/AllItems.aspx?id=%2Fsites%2Fsoci al%2Dwork%2Dmatters%2FVA%20SW%20Leadership%20Council%20Documents%2FSW%2DLC%20Diver sity%20and%20Inclusion%20Facilitation%20Guide%20May%202021%20FINAL%2Epdf&parent=%2Fsites %2Fsoci al%2Dwork%2Dmatters%2FVA%20SW%20Leadership%20Council%20Documents). Created in response to the National Social Work Action Plan to Address Racism in the VA Social Work Workforce, this guide can help EWH teams frame constructive conversations around the promotion of an inclusive workforce which is critical to well-being and resiliency, and creating safe space for dialogue around diversity, equity, and inclusion.

In addition, Chapter 19 of the [Passport to Whole Health](https://dvagov.sharepoint.com/sites/VHAOPCC/Shared%20Documents/Forms/AllItems.aspx?id=/sites/VHAOPCC/Shared%20Documents/Communications/Education%20Print%20Products/Passport%2009-2020%20for%20printing%20only.pdf&parent=/sites/VHAOPCC/Shared%20Documents/Communications/Education%20Print%20Products) (https://dvagov.sharepoint.com/sites/VHAOPCC/Shared%20Documents/Forms/AllItems.aspx?id=/sites/VHAOPCC/Shared%20Documents/Communications/Education%20Print%20Products/Passport%2009-2020%20for%20printing%20only.pdf&parent=/sites/VHAOPCC/Shared%20Documents/Communications/Education%20Print%20Products), titled “Whole Health and Community,” now offers an excellent, in-depth discussion of the impact of SDOH on various components of the Circle of Health. It also outlines specific actions that can be taken by individual providers to first elicit, and then potentially address, these factors during the patient-provider encounter.

Finally, the OPCC&CT has formally committed to address structural racism in our work surrounding Whole Health through our [OPCC&CT Statement on Racism](https://dvagov.sharepoint.com/:w:/s/VHAOPCC/WH-Implementation/EduEJiVtKZpDgqzyxJfYDFsBYsRlSr_MUfflrIctnoDgrA?e=gkc2Ld) (https://dvagov.sharepoint.com/:w:/s/VHAOPCC/WH-Implementation/EduEJiVtKZpDgqzyxJfYDFsBYsRlSr\_MUfflrIctnoDgrA?e=gkc2Ld) released in June 2020. A Social Determinants of Health course has been developed and is being piloted in FY21. In addition OPCC&CT has an internal workgroup that was formed to proactively identify opportunities for OPCC&CT staff members to rapidly increase their knowledge, skills and understanding related to diversity, equity and inclusion that will inform and enrich their personal and professional lives. The VA currently has a few national groups chartered to specifically look at SDOH for VHA patients on which OPCC&CT has formal membership and active participation; VHA Diversity, Equity & Inclusion Committee working under the Office of Resolution Management, Diversity and Inclusion (ORMDI) and the Health Equity Coalition operating under the Office of Health Equity.

**OPCC&CT’s Statement on Racism challenges everyone engaged in bringing Whole Health to our Veterans to make this commitment with us. We hope you will join us in this endeavor!**

## **Resources**

[Community Partnerships Domain SharePoint Document Library](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Community_Domain/Forms/AllItems.aspx)

([https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Community\\_Domain/Forms/AllItems.aspx](https://dvagov.sharepoint.com/sites/VHAOPCC/WH-Implementation/Community_Domain/Forms/AllItems.aspx))

## 11. Evaluating Whole Health Implementation

### 11.1 Tracking Implementation Progress using the Designation Framework and WHS Self-Assessment Tool

#### 11.1.1 Background

Published and disseminated across the VHA in March 2019, the *Designation Framework for Whole Health Implementation (DF)* and the Whole Health System Self-Assessment Tool (WHS SAT) were designed for use together at the facility/site level. Each has different features to assist with tracking progress. Together, the *Designation Framework* and WHS Self-Assessment Tool can be very useful for a site's strategic planning purposes when aligned with the site's efforts for evaluating the effectiveness of implementation efforts.

#### [The Designation Framework for Whole Health Implementation](https://dvagov.sharepoint.com/:w:/s/VHAOPCC/EUdWEp9OfqtGt3wL4-VZ3mIBIRzn6chrEYAyqfc7ffTdyw?e=flmsq5)

(<https://dvagov.sharepoint.com/:w:/s/VHAOPCC/EUdWEp9OfqtGt3wL4-VZ3mIBIRzn6chrEYAyqfc7ffTdyw?e=flmsq5>) addresses “**Where are we going?**” The journey towards Whole Health transformation is more than changing actions or completing activities. It is about changing habits and behaviors to ultimately impact our system values and beliefs. The *Designation Framework* describes this transformational journey, which ultimately (in theory) would result in full transformation and designation as a Whole Health system via a certification process. It focuses on desired outcomes in terms of what will be different at the site and, more importantly, from the Veteran perspective. To achieve these outcomes, the *Designation Framework* describes milestone accomplishments along the four phases of the Whole Health implementation journey, organized around seven domains: Governance, Operations, Pathway, Well-being Programs, Whole Health Clinical Care, Employee Whole Health, and Community Partnerships. How these accomplishments are achieved may vary from site to site.

To assist sites in determining “**Are we there yet?**” the [WHS Self-Assessment tool](https://vaww.whsassessmenttool.va.gov/login/) (<https://vaww.whsassessmenttool.va.gov/login/>) is available online. Accomplishments from each phase of the *Designation Framework* have been transferred into this tool as discrete elements that can be scored individually. The WHS Self-Assessment tool provides a structured, interactive tool for tracking *Designation Framework* accomplishments and reporting WHS implementation progress.

Upon successful completion of all elements of the *Designation Framework* and WHS Self-Assessment Tool, a site is well positioned for recognition and designation as a Whole Health site. A site must complete all accomplishments along the four phases as well as meet specific criteria for certification/designation to apply. It is anticipated and understood that sites will work through Whole Health implementation at different paces, and how each site will integrate Whole Health with other existing programs, services, partners, and stakeholders (e.g., Mental Health, Healthy Living Teams, PACT, Social Work, Public Affairs, Nursing, VSOs, etc.) will differ based on local site considerations.

**Due to the complexity and nature of organizational culture change, it is expected the journey towards Whole Health transformation will take multiple years to accomplish. As such, it is anticipated sites will not be ready for designation/certification for several years.**

### 11.1.2 How to Use the Designation Framework

It is recommended that the *Designation Framework* (a Word document) is read in its entirety before completing the online WHS Self-Assessment Tool to gain an overall understanding of how the vision for Whole Health is translated into accomplishments into seven domains. In doing so, this provides an overarching view of how different themes and topics are organized with each domain; how the related accomplishments within each domain build upon each other, and more importantly how the domains and accomplishments work together synergistically.

Also, not all elements of the *Designation Framework* are repeated in the WHS Self-Assessment Tool and the following elements can be useful for sites' planning and tracking purposes:

- Transformative Objective
- Domain Components
- Phase Overview Statements

The **Transformative Objective** provides a description of what the future state looks like for that domain and how that domain integrates with the other domains of the *Designation Framework*. The Transformative Objective is like an aim statement. Because of the intent of the Self-Assessment tool, these Transformative Objectives are not included in the tool. These Transformative Objectives can play a crucial role in identifying site-specific outcomes based on local/regional/VISN considerations and Veteran demographic and population.

Complementing the Transformative Objective for each domain, the **Domain Components** describe the key levers to achieve that described future state from the Transformative Objective. If these Domain Components aren't activated, it may be difficult for Whole Health to take root and remain sustainable. The Domain Components can assist in how a site organizes and manages its portfolio of Whole Health projects and initiatives.

In general, each phase describes the maturity stage of the Whole Health implementation journey. For example, in Phase 1/Preparation, the focus is on deliberate phased planning to support initial stand up, which includes conducting key assessments to inform implementation efforts, such as prioritizing what's feasible at initial start-up and when to expand beyond that and how. As a site progresses to Phase 2/Foundational, these accomplishments are focused on the implementation of core structure and processes so that by Phase 3/Developmental that site has the foundation to support expansion of implementation efforts which promote integration of the three Whole Health components: Pathway, Well-being programs, and Whole Health Clinical Care. By the completion of Phase 4/Full, that site's implementation efforts have resulted in full integration of all seven domains and more importantly resulted in full transformation from transactional to relational healthcare—which should align with the site's eligibility to apply for designation/certification.

Within each domain, the **Phase Overview statements** describe the impacts of implementing the specific accomplishments for that phase.

**Notably, the accomplishments build upon one another to represent incremental progress and may seem repetitive or redundant if the *Designation Framework* isn't read in its entirety.**



How these accomplishments are achieved may vary from site to site. Guidance and recommendations on the “how” can be obtained via multiple resources offered by the Office of Patient Centered Care and Cultural Transformation (OPCC&CT), to include OPCC&CT FIT consultation, [Whole Health Hub SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/SitePages/Index.aspx) (https://dvagov.sharepoint.com/sites/VHAOPCC/SitePages/Index.aspx) and this *Guide*.

### 11.1.3 How to Use the WHS Self-Assessment Tool

To assist sites in tracking completion of *Designation Framework* accomplishments and viewing overall progress by domains and phase, the online Self-Assessment Tool offers both a Checklist and a Dashboard for designated site-level Whole Health Points of Contact (POCs). The Checklist is used by the Whole Health POCs to enter Whole Health implementation progress data. The Dashboard tab within the tool offers site, VISN, and national leaders a customizable and easy-to-read graphical summary of Whole Health implementation progress. Depending on a user’s level of access, the Dashboard can display implementation progress for an individual site, at a VISN level, or at a national level.

It is recommended that each site review its Checklist of accomplishments on a monthly basis (or as often as required by local/VISN leadership). At minimum, it is recommended that sites report data for the last month of each quarter (December, March, July and September) to provide four data points per fiscal year. A site’s Whole Health Steering Committee (or other entity overseeing Whole Health implementation) is anticipated to take the lead in this effort, involving the ELT and senior leadership to support strategic and operational decision making and quality improvement efforts. While the Self-Assessment Tool tracks completion of DF accomplishments, the tool by itself isn’t intended to evaluate effectiveness of implementation activities. At a minimum, a regular review of the Checklist should coincide with the site’s plan for tracking and monitoring Whole Health utilization, cost data, and outcomes.

**It is important that sites answer “yes” to a Checklist question only when an accomplishment is 100% complete. Partial credit is not given. This is because the *Designation Framework* is already designed to capture incremental progress by defining actions that build upon each other across the four phases of implementation. To maintain the integrity of cross-site comparisons, all sites need to score themselves using this approach.**

Guidance and recommendations on the “how” of Whole Health implementation can be obtained via multiple resources offered by the Office of Patient Centered Care and Cultural Transformation (OPCC&CT), to include OPCC&CT FIT consultation, [Whole Health Hub SharePoint](https://dvagov.sharepoint.com/sites/VHAOPCC/SitePages/Index.aspx) (https://dvagov.sharepoint.com/sites/VHAOPCC/SitePages/Index.aspx) and this *Guide*. Sites are encouraged to use a multi-disciplinary approach to complete the Checklist items so that the expertise and knowledge of all stakeholders is represented in the final data submission.

Ultimately, completion and achievement of the *Designation Framework* accomplishments provides a site the opportunity to apply for recognition as a Whole Health site. A site must complete all accomplishments along the four phases as well as meet specific criteria for designation/certification.

## 11.2 Evaluating Whole Health Implementation Progress

### 11.2.1 Formal Evaluation of Flagship Sites

Whole Health has been ongoing in the VA since 2011, as VA employees have been working with Veterans around the country to implement this approach. The Whole Health System (WHS) model is based on the experience of over two hundred innovation projects, followed by a total of thirty-one selected design sites across FY16-18, together with 140 other facilities that are advancing this approach.

In FY18, VA launched the Whole Health System at 18 Flagship Sites in response to requirements of the Comprehensive Addiction and Recovery Act (CARA) of 2016 legislation, aimed in part at addressing the problems of opioid addiction and chronic pain management among Veterans. This legislation required VA to conduct research on the impact of CIH on Veterans. OPCC&CT partnered with the Center for Evaluating Patient Centered Care in the VA (EPCC) and the Quality Enhancement Research Initiative (QUERI) to conduct this research.

In July 2020, the “[Whole Health System of Care Evaluation—A Progress Report on the Outcomes of the WHS Pilot at 18 Flagship Sites](https://www.va.gov/WHOLEHEALTH/docs/EPCCWholeHealthSystemofCareEvaluation-2020-02-18FINAL_508.pdf)”

([https://www.va.gov/WHOLEHEALTH/docs/EPCCWholeHealthSystemofCareEvaluation-2020-02-18FINAL\\_508.pdf](https://www.va.gov/WHOLEHEALTH/docs/EPCCWholeHealthSystemofCareEvaluation-2020-02-18FINAL_508.pdf)) was submitted to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives. The report included:

- Progress towards implementation of the WHS
- Utilization of Whole Health services
- Impact of Whole Health service use on Veterans health and Well-being
- Impact of the WHS implementation on employees

This report can be a useful reference for sites to learn about the Flagship Sites’ implementation experiences and methodologies for evaluation. (Of note, the tracking rubric used in the Flagship report is *not* the same as that in the *Designation Framework* or WHS Self-Assessment Tool). Future Flagship evaluation and related reports will be published on the [OPCC&CT Research & Evaluation SharePoint](https://www.va.gov/WHOLEHEALTH/professional-resources/clinician-tools/Evidence-Based-Research.asp) (<https://www.va.gov/WHOLEHEALTH/professional-resources/clinician-tools/Evidence-Based-Research.asp>).

### 11.2.2 Additional Evaluation Resources

Similar to the Flagship report’s approach, sites can evaluate effectiveness of Whole Health implementation efforts by looking at:

- Utilization of the WHS
- Impact on Veterans
- Impact on VA employees

Sites may choose to develop additional evaluation strategies pertinent to site-specific priority outcomes not addressed here. FIT Consultants are available to aid in achieving implementation milestones and facilitate in the development of a site-specific measurement plan for sites that want to expand on the national evaluation targets.

### *11.2.2.1 Evaluating Utilization of the Whole Health System*

Utilization of the Whole Health System can be evaluated through methods described in the [WHS Coding and Tracking Guidance](https://dvagov.sharepoint.com/sites/VHAOPCC/SitePages/Whole-Health-System-Coding-Guidance.aspx) (https://dvagov.sharepoint.com/sites/VHAOPCC/SitePages/Whole-Health-System-Coding-Guidance.aspx) to help sites accurately document approaches they provide in the support of Whole Health. Refer to the WHS Coding and Tracking Guidance to learn more about the six major elements of Whole Health tracking: Clinic stop codes (within count or non-count clinics); CHAR4 codes, Integrative Health Note title, Procedure codes, and Health Factors. By tracking these elements, sites can gain a better understanding of its Whole Health utilization and demand, workload, and VERA and productivity.

OPCC&CT, in conjunction with the Managerial and Cost Accounting Office (MCAO), has also established a new Whole Health cohort. A cost and utilization tracking mechanism was developed that came online in October 2017, providing aggregate cost and utilization data year-to-date for the following:

- Total Cost
- Total inpatient cost
- Total outpatient cost by Primary Care STOP Codes, Rehab (physical therapy, occupational therapy), Orthopedics, Mental Health, Radiology, Surgical Procedures, Laboratory, and Pharmacy (Opioid use)

Metrics include:

- Average cost per patient
- Average cost per encounter
- Total and average costs for the cohort
- Cost breakouts for direct and indirect cost, number of admissions, bed days of care (lengths of stay), emergency department and urgent care encounters, and readmissions

These parameters serve as ongoing quality measures and will allow an evaluation of the impact of deploying the WHS on cost and utilization at each facility and nationally.

### *11.2.2.2 Evaluating Impact on Veterans*

#### **What does it mean to talk about “clinical outcomes” of Whole Health for Veterans?**

When clinicians (and some VA leaders) talk about looking for more evidence regarding the “clinical outcomes” of Whole Health, they are often referring to disease-specific biomarkers, like HemoglobinA1C in diabetics or blood pressure in people with hypertension. This is because we work in a disease-oriented system—so naturally people think of disease-oriented outcomes as the most important.

However, **the term “clinical outcomes,” according to the FDA—which is the group ultimately responsible for approving medications, new technologies and devices which are currently thought of as the essential components of conventional health care—is defined much more broadly:**

- Clinical Outcome Assessment: a measure that describes or reflects how a patient feels, functions, or survives.

- [Patient-reported outcome \(PRO\) measures](https://www.ncbi.nlm.nih.gov/books/NBK338448/def-item/glossary.patientreported-outcome/)  
(https://www.ncbi.nlm.nih.gov/books/NBK338448/def-item/glossary.patientreported-outcome/): based on a report that comes directly from the patient (i.e., study subject) about the status of a patient's health condition without amendment or interpretation of the patient's response by a clinician or anyone else
- [Observer-reported outcome \(ObsRO\) measures](https://www.ncbi.nlm.nih.gov/books/NBK338448/def-item/glossary.observerreported-outcome/)  
(https://www.ncbi.nlm.nih.gov/books/NBK338448/def-item/glossary.observerreported-outcome/): based on a report of observable signs, events or behaviors related to a patient's health condition by someone other than the patient or a health professional
- [Clinician-reported outcome \(ClinRO\) measures](https://www.ncbi.nlm.nih.gov/books/NBK338448/def-item/glossary.clinicianreported-outcome/)  
(https://www.ncbi.nlm.nih.gov/books/NBK338448/def-item/glossary.clinicianreported-outcome/): based on a report that comes from a trained health-care professional after observation of a patient's health condition (this category includes biomarkers like lab values)
- [Performance outcome \(PerfO\) measures](https://www.ncbi.nlm.nih.gov/books/NBK338448/def-item/glossary.performance-outcome/)  
(https://www.ncbi.nlm.nih.gov/books/NBK338448/def-item/glossary.performance-outcome/): based on standardized task(s) actively undertaken by a patient according to a set of instructions

**Thus, patient-reported outcomes like quality of life, pain, and life meaning and purpose are considered just as legitimate as biomarkers are in government decision-making regarding what constitutes an evidence-supported treatment or approach.**

Most clinicians trained in disease management, as opposed to well-being and health creation, often have trouble seeing the importance of clinical outcomes beyond the biomarker category. This creates a challenge because Whole Health targets the well-being of the person as a whole, and not the outcomes of a specific disease. As a result, the likelihood that we will see huge impacts of Whole Health engagement on specific disease biomarkers is fairly small. Thus, it is vital to help educate both clinicians and leaders that patient reported outcomes are considered legitimate clinical outcomes for the purposes of evidence-based decision-making.

A detailed evaluation plan was developed for the Flagship Sites by the OPCC&CT in collaboration with Health Services Research and Development Service's (HSR&D) Quality Enhancement Research Initiative (QUERI) to achieve the objective of the CARA/Whole Health System (WHS) evaluation effort. The evaluation plan included specific strategies for gathering outcomes in the areas of Veteran satisfaction and experience, patient-reported health outcomes, employee engagement and well-being, and clinical outcomes. These strategies are organized in the [Whole Health Evaluation Toolkit](https://dvagov.sharepoint.com/sites/VHAOPCC/Shared Documents/Forms/AllItems.aspx?RootFolder=/sites/VHAOPCC/Shared%20Documents/Research/1.OPCC CT%20Research%20Projects/Evaluation%20Toolkit/WH_Evaluation_Toolkit&FolderCTID=0x01200092D5EAC253479641B8D0A20FE4165E94&View=%7b4AD754A9-57D5-4A13-A317-D62DAB4881EB%7d) (https://dvagov.sharepoint.com/sites/VHAOPCC/Shared Documents/Forms/AllItems.aspx?RootFolder=/sites/VHAOPCC/Shared%20Documents/Research/1.OPCC CT%20Research%20Projects/Evaluation%20Toolkit/WH\_Evaluation\_Toolkit&FolderCTID=0x01200092D5EAC253479641B8D0A20FE4165E94&View=%7b4AD754A9-57D5-4A13-A317-D62DAB4881EB%7d). The Whole Health Evaluation Toolkit and is designed to be used by staff in VA who are implementing Whole Health. It is intended to assist sites in learning why and how to evaluate outcomes associated with the implementation of the full system or components of it.

### 11.2.2.3 Evaluating Impact on VA Employees

Early findings from the Flagship Evaluation Report revealed that employees who reported involvement with Whole Health reported lower voluntary turnover, lower burnout, and greater motivation. Facilities with higher employee involvement in Whole Health had higher ratings on hospital performance, as measured by Strategic Analytics for Improvement and Learning (SAIL). Facilities with higher employee involvement in Whole Health had higher ratings from Veterans on receiving patient-centered care as measured in the Survey of Healthcare Experiences of Patients (SHEP). The [EWH Evaluation Toolkit](https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/WH-Implementation/_layouts/15/Doc.aspx?sourcedoc=%7BF98B60E8-E3D8-42E6-BE5E-1CC0C968B029%7D&file=EWH_Evaluation_Toolkit.docx&action=default&mobileredirect=true) (https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/WH-Implementation/\_layouts/15/Doc.aspx?sourcedoc=%7BF98B60E8-E3D8-42E6-BE5E-1CC0C968B029%7D&file=EWH\_Evaluation\_Toolkit.docx&action=default&mobileredirect=true) includes a series of measures and scales for use in evaluation efforts around Employee Whole Health. In addition, refer to section 9.9 [Establishing Evidence of the Value of Whole Health through its Influence on Employee Satisfaction and Engagement](#) of this *Guide* for further information.

## Resources

[Whole Health Evaluation Toolkit](https://dvagov.sharepoint.com/sites/VHAOPCC/SharedDocuments/Forms/AllItems.aspx?RootFolder=/sites/VHAOPCC/Shared%20Documents/Research/1.OPCCCT%20Research%20Projects/Evaluation%20Toolkit/WH_Evaluation_Toolkit&FolderCTID=0x01200092D5EAC253479641B8D0A20FE4165E94&View=%7b4AD754A9-57D5-4A13-A317-D62DAB4881EB%7d) (https://dvagov.sharepoint.com/sites/VHAOPCC/SharedDocuments/Forms/AllItems.aspx?RootFolder=/sites/VHAOPCC/Shared%20Documents/Research/1.OPCCCT%20Research%20Projects/Evaluation%20Toolkit/WH\_Evaluation\_Toolkit&FolderCTID=0x01200092D5EAC253479641B8D0A20FE4165E94&View=%7b4AD754A9-57D5-4A13-A317-D62DAB4881EB%7d)

[EWH Evaluation Toolkit](https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/WH-Implementation/_layouts/15/Doc.aspx?sourcedoc=%7BF98B60E8-E3D8-42E6-BE5E-1CC0C968B029%7D&file=EWH_Evaluation_Toolkit.docx&action=default&mobileredirect=true) (https://dvagov.sharepoint.com/:w:/r/sites/VHAOPCC/WH-Implementation/\_layouts/15/Doc.aspx?sourcedoc=%7BF98B60E8-E3D8-42E6-BE5E-1CC0C968B029%7D&file=EWH\_Evaluation\_Toolkit.docx&action=default&mobileredirect=true)

## 12. Glossary

ACE	Altarum Consumer Engagement
ACOS	Associate Chief of Staff
ACP	American College of Physicians
ADPAC	Automated Data Processing Application Coordinator
AES	All Employee Survey
AMA	American Medical Association
BFA	Battlefield Acupuncture
CAC	Clinical Application Coordinator
CARE	Consultation and Relational Empathy
CBOC	Community Based Outpatient Clinic
CIH	Complementary and Integrative Health
CIHEC	Complementary and Integrative Health Evaluation Center
CITC	Care in the Community
CoP	Community of Practice
CPT	Current Procedural Terminology (CPT)
CVEB	Community Veterans Engagement Board
CVT	Clinical Video Telehealth
CPRS	Computerized Patient Record System
DF	Designation Framework for Whole Health Implementation
DOD	Department of Defense
DVPRS	Defense and Veterans Pain Rating Scale
EAP	Employee Assistance Program
EDM	Executive Decision Memo
EES	Employee Education Service
EHR	Electronic Health Record
ELT	Executive Leadership Team
EMF	Employee Medical Folder

EOH	Employee Occupational Health
EPCC	Center for Evaluating Patient-Centered Care
EWB	Employee Whole Health
FEC	Flagship Education Champion
FEHB	Federal Employees Health Benefits
FIT	Field Implementation Team
FTE	Full-Time Equivalent
FWS	Flexible Work Schedules
HBC	Home Based Care
HE	Healing Environment
HIMS	Health Information Management Services
HIPPA	Health Insurance Portability and Accountability Act
HLA	Healthy Living Assessment
HPDP	Health Promotion Disease Prevention
HSR&D	Health Services Research & Development
IHCC	Integrative Health Coordinating Center
IPT	Integrated Project Team
LoEC	Local Education Champion
MAP	Mission, Aspiration, and Purpose
MCAO	Managerial and Cost Accounting Office
MCD	Medical Center Director
MEQ	Mindful Eating Questionnaire
MI	Motivational Interviewing
MOU	Memorandum of Understanding
MSA	Medical Support Assistant
NBHCW	National Board for Health & Wellness Coaching
NCOD	National Center for Organization Development
NCP	National Center for Health Promotion and Disease Prevention
NEO	New Employee Orientation



NRT	Nicotine replacement therapy
NS	Network Sponsor (for Whole Health)
NWEC	Network-Wide Education Coordinator
NWEF	Network-Wide Education Faculty
OHE	Office of Health Equity
OMHSP	Office of Mental Health and Suicide Prevention
OPCC&CT	Office of Patient Centered Care & Cultural Transformation
OPES	Office of Productivity, Efficiency, and Staffing
OPM	Office of Personnel Management
PACT	Patient Aligned Care Team(s)
PCMHI	Primary Care Mental Health Integration
PCP	Primary Care Provider/Physician
PD	Position Description
PEG	Pain, Enjoyment, General Activity
PFAC	Patient Family Advisory Committee/Council
PHP	Personal Health Plan
PHI	Personal Health Inventory
POC	Point of Contact
PSS	Perceived Stress Scale
QUERI	Quality Enhancement Research Initiative
ROI	Return on Investment
RTC	Return to Clinic
RVU	Relative Value Unit
SAIL	Strategic Analytics for Improvement and Learning
SDOH	Social Determinants of Health
SHEP	Survey of Healthcare Experiences of Patients
SMA	Shared Medical Appointment
SMART	SMART Goals = Specific, Measurable, Action-Oriented, Realistic, Timebound
SME	Subject Matter Expert

SOP	Standard Operating Procedure
SORN	System of Records Notice
SVA	Student Veteran Association
TCMLH	Taking Charge of My Life and Health
TMS	Talent Management System
TTT	Train the Trainer
VA	Veterans Administration
VA HRA/OSP	VA Human Resources and Administration/Operations, Security, and Preparedness
VBA	Veterans Benefits Administration
VCP	Veteran Community Partnerships
VEO	Veteran Experience Office
VHA	Veterans Health Administration
VISN	Veteran Integrated Service Network
VISTA	Veterans Health Information Systems and Technology Architecture
VOI	Value on investment
VSO	Veteran Service Organization
VSSC	VHA Support Service Center Capital Assets database
VVC	VA Video Connect
WBP	Well-being Programs
WH	Whole Health
WHCC	Whole Health Clinical Care
WHIG	Whole Health System Implementation Guide
WHS	Whole Health System
WHS SAT	Whole Health System Self-Assessment Tool
WMC	Workforce Management and Consulting
WOC	Without Compensation